

111TH CONGRESS
1ST SESSION

S. 1262

To amend title VII of the Public Health Service Act and titles XVIII and XIX of the Social Security Act to provide additional resources for primary care services, to create new payment models for services under Medicare, to expand provision of non-institutionally-based long-term services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 15, 2009

Ms. CANTWELL introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title VII of the Public Health Service Act and titles XVIII and XIX of the Social Security Act to provide additional resources for primary care services, to create new payment models for services under Medicare, to expand provision of non-institutionally-based long-term services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medical Efficiency and
5 Delivery Improvement of Care Act (MEDIC) of 2009”.

1 **SEC. 2. TABLE OF CONTENTS.**

2 The table of contents for this Act is as follows:

- Sec. 1. Short title.
- Sec. 2. Table of contents.

TITLE I—LOAN PROGRAM PROVISIONS

- Sec. 1001. Short title.
- Sec. 1002. Hospital residency loan program.

TITLE II—PRIMARY CARE PROVISIONS

- Sec. 2001. Short title.
- Sec. 2002. Findings.
- Sec. 2003. Definitions.

Subtitle A—Medical Education

- Sec. 2101. Recruitment incentives.
- Sec. 2102. Debt forgiveness, scholarships, and service obligations.
- Sec. 2103. Deferment of loans during residency and internships.
- Sec. 2104. Educating medical students about primary care careers.
- Sec. 2105. Training in family medicine, general internal medicine, general geriatrics, general pediatrics, physician assistant education, general dentistry, and pediatric dentistry.
- Sec. 2106. Increased funding for National Health Service Corps Scholarship and loan repayment programs.

Subtitle B—Medicaid Related Provisions

- Sec. 2201. Transformation grants to support patient-centered medical homes under Medicaid and CHIP.

Subtitle C—Medicare Provisions

PART I—PRIMARY CARE

- Sec. 2301. Reforming payment systems under Medicare to support primary care.
- Sec. 2302. Coverage of patient-centered medical home services.
- Sec. 2303. Medicare primary care payment equity and access provision.
- Sec. 2304. Additional incentive payment program for primary care services furnished in health professional shortage areas.
- Sec. 2305. Permanent extension of Medicare incentive payment program for physician scarcity areas.
- Sec. 2306. HHS study and report on the process for determining relative value under the Medicare physician fee schedule.

PART II—PREVENTIVE SERVICES

- Sec. 2311. Eliminating time restriction for initial preventive physical examination.
- Sec. 2312. Elimination of cost-sharing for preventive benefits under the Medicare program.
- Sec. 2313. HHS study and report on facilitating the receipt of Medicare preventive services by Medicare beneficiaries.

PART III—OTHER PROVISIONS

- Sec. 2321. HHS study and report on improving the ability of physicians and primary care providers to assist Medicare beneficiaries in obtaining needed prescriptions under Medicare part D.
- Sec. 2322. HHS study and report on improved patient care through increased caregiver and physician interaction.
- Sec. 2323. Improved patient care through expanded support for limited English proficiency (LEP) services.
- Sec. 2324. HHS study and report on use of real-time Medicare claims adjudication.
- Sec. 2325. Ongoing assessment by MedPAC of the impact of Medicare payments on primary care access and equity.
- Sec. 2326. Distribution of additional residency positions.
- Sec. 2327. Counting resident time in outpatient settings.
- Sec. 2328. Rules for counting resident time for didactic and scholarly activities and other activities.
- Sec. 2329. Preservation of resident cap positions from closed and acquired hospitals.
- Sec. 2330. Quality improvement organization assistance for physician practices seeking to be patient-centered medical home practices.

Subtitle D—Studies

- Sec. 2401. Study concerning the designation of primary care as a shortage profession.
- Sec. 2402. Study concerning the education debt of medical school graduates.
- Sec. 2403. Study on minority representation in primary care.

TITLE III—MEDICARE PAYMENT PROVISIONS

- Sec. 3001. Short title.
- Sec. 3002. Findings.
- Sec. 3003. Value index under the Medicare physician fee schedule.

TITLE IV—LONG-TERM SERVICES PROVISIONS

- Sec. 4001. Short title.

Subtitle A—Balancing Incentives

- Sec. 4101. Enhanced FMAP for expanding the provision of non-institutionally-based long-term services and supports.

Subtitle B—Strengthening the Medicaid Home and Community-Based State Plan Amendment Option

- Sec. 4201. Removal of barriers to providing home and community-based services under State plan amendment option for individuals in need.
- Sec. 4202. Mandatory application of spousal impoverishment protections to recipients of home and community-based services.
- Sec. 4203. State authority to elect to exclude up to 6 months of average cost of nursing facility services from assets or resources for purposes of eligibility for home and community-based services.

Subtitle C—Coordination of Home and Community-Based Waivers

Sec. 4301. Streamlined process for combined waivers under subsections (b) and (c) of section 1915.

TITLE V—HOME AND COMMUNITY-BASED SERVICES PROVISIONS

Sec. 5001. Short title.

Sec. 5002. Long-term services and supports.

1 **TITLE I—LOAN PROGRAM** 2 **PROVISIONS**

3 **SEC. 1001. SHORT TITLE.**

4 This title may be cited as the “Physician Workforce
5 Enhancement Act of 2009”.

6 **SEC. 1002. HOSPITAL RESIDENCY LOAN PROGRAM.**

7 Subpart 2 of part E of title VII of the Public Health
8 Service Act is amended by adding at the end the following
9 new section:

10 **“SEC. 771. HOSPITAL RESIDENCY LOAN PROGRAM.**

11 “(a) ESTABLISHMENT.—Not later than January 1,
12 2010, the Secretary, acting through the Administrator of
13 the Health Resources and Services Administration, shall
14 establish a loan program that provides loans to eligible
15 hospitals to establish residency training programs.

16 “(b) APPLICATION.—No loan may be provided under
17 this section to an eligible hospital except pursuant to an
18 application that is submitted and approved in a time, man-
19 ner, and form specified by the Administrator of the Health
20 Resources and Services Administration. A loan under this
21 section shall be on such terms and conditions and meet

1 such requirements as the Administrator determines appro-
 2 priate, in accordance with the provisions of this section.

3 “(c) ELIGIBILITY; PREFERENCE FOR RURAL AND
 4 SMALL URBAN AREAS.—

5 “(1) ELIGIBLE HOSPITAL DEFINED.—For pur-
 6 poses of this section, an ‘eligible hospital’ means,
 7 with respect to a loan under this section, a hospital
 8 that, as of the date of the submission of an applica-
 9 tion under subsection (b), meets, to the satisfaction
 10 of the Administrator of the Health Resources and
 11 Services Administration, each of the following cri-
 12 teria:

13 “(A) The hospital does not operate a resi-
 14 dency training program, has not previously op-
 15 erated such a program, and has not taken any
 16 significant action, such as the expenditure of a
 17 material amount of funds, before July 1, 2009,
 18 to establish such a program.

19 “(B) The hospital has secured initial ac-
 20 creditation by the American Council for Grad-
 21 uate Medical Education or the American Osteo-
 22 pathic Association.

23 “(C) The hospital provides assurances to
 24 the satisfaction of the Administrator of the
 25 Health Resources and Services Administration

that such loan shall be used, consistent with subsection (d), only for the purposes of establishing and conducting an allopathic or osteopathic physician residency training program in at least one of the following medical specialties, or a combination of the following:

“(i) Family medicine.

“(ii) Internal medicine.

“(iii) Emergency medicine.

“(iv) Obstetrics or gynecology.

“(v) General surgery.

“(vi) Preventive Medicine.

“(vii) Pediatrics.

“(viii) Behavioral and Mental Health.

“(D) The hospital enters into an agreement with the Administrator that certifies the hospital will provide for the repayment of the loan in accordance with subsection (e).

“(2) PREFERENCE FOR RURAL AND SMALL AREAS.—In making loans under this section, the Administrator of the Health Resources and Services Administration shall give preference to any applicant for such a loan that is a hospital located in a rural areas (as such term is defined in section 1886(d)(2)(D) of the Social Security Act) or an

1 urban area that is not a large urban area (as such
2 terms are respectively defined in such section).

3 “(d) PERMISSIBLE USES OF LOAN FUNDS.—A loan
4 provided under this section shall be used, with respect to
5 a residency training program, only for costs directly at-
6 tributable to the residency training program, except as
7 otherwise provided by the Administrator of the Health Re-
8 sources and Services Administration.

9 “(e) REPAYMENT OF LOANS.—

10 “(1) REPAYMENT PLANS.—For purposes of
11 subsection (c)(1)(D), a repayment plan for an eligi-
12 ble hospital is in accordance with this subsection if
13 it provides for the repayment of the loan amount in
14 installments, in accordance with a schedule that is
15 agreed to by the Administrator of the Health Re-
16 sources and Services Administration and the hospital
17 and that is in accordance with this subsection.

18 “(2) COMMENCEMENT OF REPAYMENT.—Re-
19 payment by an eligible hospital of a loan under this
20 section shall commence not later than the date that
21 is 18 months after the date on which the loan
22 amount is disbursed to such hospital.

23 “(3) REPAYMENT PERIOD.—A loan made under
24 this section shall be fully repaid not later than the

1 date that is 24 months after the date on which the
2 repayment is required to commence.

3 “(4) LOAN PAYABLE IN FULL IF RESIDENCY
4 TRAINING PROGRAM CANCELED.—In the case that
5 an eligible hospital borrows a loan under this sec-
6 tion, with respect to a residency training program,
7 and terminates such program before the date on
8 which such loan has been fully repaid in accordance
9 with a plan under paragraph (1), such loan shall be
10 payable by the hospital not later than 45 days after
11 the date of such termination.

12 “(f) NO INTEREST CHARGED.—The Administrator of
13 the Health Resources and Services Administration may
14 not charge or collect interest on any loan made under this
15 section.

16 “(g) LIMITATION ON TOTAL AMOUNT OF LOAN.—
17 The cumulative dollar amount of a loan made to an eligible
18 hospital under this section may not exceed \$1,000,000.

19 “(h) PENALTIES.—The Administrator of the Health
20 Resources and Services Administration shall establish pen-
21 alties to which an eligible hospital receiving a loan under
22 this section would be subject if such hospital is in violation
23 of any of the criteria described in subsection (c)(1).

24 “(i) REPORTS.—Not later than January 1, 2014, and
25 annually thereafter (before January 2, 2020), the Admin-

1 istrator of the Health Resources and Services Administra-
 2 tion shall submit to Congress a report on the efficacy of
 3 the program under this section in increasing the number
 4 of residents practicing in each medical specialty described
 5 in subsection (c)(1)(C) during such year and the extent
 6 to which the program resulted in an increase in the num-
 7 ber of available practitioners in each of such medical spe-
 8 cialties that serve medically underserved populations.

9 “(j) FUNDING.—

10 “(1) AUTHORIZATION OF APPROPRIATIONS.—

11 For the purpose of providing amounts for loans
 12 under this section, there are authorized to be appro-
 13 priated \$25,000,000 for the period of fiscal years
 14 2010 through 2020.

15 “(2) AVAILABILITY.—Amounts appropriated
 16 under paragraph (1) shall remain available until ex-
 17 pended.

18 “(3) REPAID LOAN AMOUNTS.—Any amount re-
 19 paid by, or recovered from, an eligible hospital under
 20 this section on or before the date of termination de-
 21 scribed in subsection (k) shall be credited to the ap-
 22 propriation account from which the loan amount in-
 23 volved was originally paid. Any amount repaid by, or
 24 recovered from, such a hospital under this section

1 after such date shall be credited to the general fund
2 in the Treasury.

3 “(k) TERMINATION OF PROGRAM.—No loan may be
4 made under this section after December 31, 2019.”.

5 **TITLE II—PRIMARY CARE** 6 **PROVISIONS**

7 **SEC. 2001. SHORT TITLE.**

8 This title may be cited as the “Preserving Patient
9 Access to Primary Care Act of 2009”.

10 **SEC. 2002. FINDINGS.**

11 Congress makes the following findings:

12 (1) Approximately 21 percent of physicians who
13 were board certified in general internal medicine
14 during the early 1990s have left internal medicine,
15 compared to a 5 percent departure rate for those
16 who were certified in subspecialties of internal medi-
17 cine.

18 (2) The number of United States medical grad-
19 uates going into family medicine has fallen by more
20 than 50 percent from 1997 to 2005.

21 (3) In 2007, only 88 percent of the available
22 medicine residency positions were filled and only 42
23 percent of those were filled by United States medical
24 school graduates.

1 (4) In 2006, only 24 percent of third-year inter-
2 nal medicine resident intended to pursue careers in
3 general internal medicine, down from 54 percent in
4 1998.

5 (5) Primary care physicians serve as the point
6 of first contact for most patients and are able to co-
7 ordinate the care of the whole person, reducing un-
8 necessary care and duplicative testing.

9 (6) Primary care physicians and primary care
10 providers practicing preventive care, including
11 screening for illness and treating diseases, can help
12 prevent complications that result in more costly
13 care.

14 (7) Patients with primary care physicians or
15 primary care providers have lower health care ex-
16 penditures and primary care is correlated with better
17 health status, lower overall mortality, and longer life
18 expectancy.

19 (8) Higher proportions of primary care physi-
20 cians are associated with significantly reduced utili-
21 zation.

22 (9) The United States has a higher ratio of spe-
23 cialists to primary care physicians than other indus-
24 trialized nations and the population of the United

1 States is growing faster than the expected rate of
2 growth in the supply of primary care physicians.

3 (10) The number of Americans age 65 and
4 older, those eligible for Medicare and who use far
5 more ambulatory care visits per person as those
6 under age 65, is expected to double from 2000 to
7 2030.

8 (11) A decrease in Federal spending to carry
9 out programs authorized by title VII of the Public
10 Health Service Act threatens the viability of one of
11 the programs used to solve the problem of inad-
12 equate access to primary care.

13 (12) The National Health Service Corps pro-
14 gram has a proven record of supplying physicians to
15 underserved areas, and has played an important role
16 in expanding access for underserved populations in
17 rural and inner city communities.

18 (13) Individuals in many geographic areas, es-
19 pecially rural areas, lack adequate access to high
20 quality preventive, primary health care, contributing
21 to significant health disparities that impair Amer-
22 ica's public health and economic productivity.

23 (14) About 20 percent of the population of the
24 United States resides in primary medical care
25 Health Professional Shortage Areas.

1 **SEC. 2003. DEFINITIONS.**

2 (a) GENERAL DEFINITIONS.—In this title:

3 (1) CHRONIC CARE COORDINATION.—The term
4 “chronic care coordination” means the coordination
5 of services that is based on the Chronic Care Model
6 that provides on-going health care to patients with
7 chronic diseases that may include any of the fol-
8 lowing services:

9 (A) The development of an initial plan of
10 care, and subsequent appropriate revisions to
11 such plan of care.

12 (B) The management of, and referral for,
13 medical and other health services, including
14 interdisciplinary care conferences and manage-
15 ment with other providers.

16 (C) The monitoring and management of
17 medications.

18 (D) Patient education and counseling serv-
19 ices.

20 (E) Family caregiver education and coun-
21 seling services.

22 (F) Self-management services, including
23 health education and risk appraisal to identify
24 behavioral risk factors through self-assessment.

25 (G) Providing access by telephone with
26 physicians and other appropriate health care

1 professionals, including 24-hour availability of
 2 such professionals for emergencies.

3 (H) Management with the principal non-
 4 professional caregiver in the home.

5 (I) Managing and facilitating transitions
 6 among health care professionals and across set-
 7 tings of care, including the following:

8 (i) Pursuing the treatment option
 9 elected by the individual.

10 (ii) Including any advance directive
 11 executed by the individual in the medical
 12 file of the individual.

13 (J) Information about, and referral to,
 14 hospice care, including patient and family care-
 15 giver education and counseling about hospice
 16 care, and facilitating transition to hospice care
 17 when elected.

18 (K) Information about, referral to, and
 19 management with, community services.

20 (2) CRITICAL SHORTAGE HEALTH FACILITY.—

21 The term “critical shortage health facility” means a
 22 public or private nonprofit health facility that does
 23 not serve a health professional shortage area (as
 24 designated under section 332 of the Public Health
 25 Service Act), but that has a critical shortage of phy-

1 sicians (as determined by the Secretary) in a pri-
2 mary care field.

3 (3) PHYSICIAN.—The term physician has the
4 meaning given such term in section 1861(r)(1) of
5 the Social Security Act.

6 (4) PRIMARY CARE.—The term “primary care”
7 means the provision of integrated, high-quality, ac-
8 cessible health care services by health care providers
9 who are accountable for addressing a full range of
10 personal health and health care needs, developing a
11 sustained partnership with patients, practicing in
12 the context of family and community, and working
13 to minimize disparities across population subgroups.

14 (5) PRIMARY CARE FIELD.—The term “primary
15 care field” means any of the following fields:

16 (A) The field of family medicine.

17 (B) The field of general internal medicine.

18 (C) The field of geriatric medicine.

19 (D) The field of pediatric medicine

20 (6) PRIMARY CARE PHYSICIAN.—The term “pri-
21 mary care physician” means a physician who is
22 trained in a primary care field who provides first
23 contact, continuous, and comprehensive care to pa-
24 tients.

1 (7) PRIMARY CARE PROVIDER.—The term “pri-
2 mary care provider” means—

3 (A) a nurse practitioner; or

4 (B) a physician assistant practicing as a
5 member of a physician-directed team;
6 who provides first contact, continuous, and com-
7 prehensive care to patients.

8 (8) PRINCIPAL CARE.—The term “principal
9 care” means integrated, accessible health care that
10 is provided by a physician who is a medical sub-
11 specialist that addresses the majority of the personal
12 health care needs of patients with chronic conditions
13 requiring the subspecialist’s expertise, and for whom
14 the subspecialist assumes care management, devel-
15 oping a sustained physician-patient partnership and
16 practicing within the context of family and commu-
17 nity.

18 (9) SECRETARY.—The term “Secretary” means
19 the Secretary of Health and Human Services.

20 (b) PRIMARY MEDICAL CARE SHORTAGE AREA.—

21 (1) IN GENERAL.—In this title, the term “pri-
22 mary medical care shortage area” or “PMCSA”
23 means a geographic area with a shortage of physi-
24 cians (as designated by the Secretary) in a primary

1 care field, as designated in accordance with para-
2 graph (2).

3 (2) DESIGNATION.—To be designated by the
4 Secretary as a PMCSA, the Secretary must find
5 that the geographic area involved has an established
6 shortage of primary care physicians for the popu-
7 lation served. The Secretary shall make such a des-
8 ignation with respect to an urban or rural geo-
9 graphic area if the following criteria are met:

10 (A) The area is a rational area for the de-
11 livery of primary care services.

12 (B) One of the following conditions pre-
13 vails within the area:

14 (i) The area has a population to full-
15 time-equivalent primary care physician
16 ratio of at least 3,500 to 1.

17 (ii) The area has a population to full-
18 time-equivalent primary care physician
19 ratio of less than 3,500 to 1 and has un-
20 usually high needs for primary care serv-
21 ices or insufficient capacity of existing pri-
22 mary care providers.

23 (C) Primary care providers in contiguous
24 geographic areas are overutilized.

25 (c) MEDICALLY UNDERSERVED AREA.—

1 (1) IN GENERAL.—In this title, the term “medi-
 2 cally underserved area” or “MUA” means a rational
 3 service area with a demonstrable shortage of pri-
 4 mary healthcare resources relative to the needs of
 5 the entire population within the service area as de-
 6 termined in accordance with paragraph (2) through
 7 the use of the Index of Medical Underservice (re-
 8 ferred to in this subsection as the “IMU”) with re-
 9 spect to data on a service area.

10 (2) DETERMINATIONS.—Under criteria to be
 11 established by the Secretary with respect to the
 12 IMU, if a service area is determined by the Sec-
 13 retary to have a score of 62.0 or less, such area shall
 14 be eligible to be designated as a MUA.

15 (3) IMU VARIABLES.—In establishing criteria
 16 under paragraph (2), the Secretary shall ensure that
 17 the following variables are utilized:

18 (A) The ratio of primary medical care phy-
 19 sicians per 1,000 individuals in the population
 20 of the area involved.

21 (B) The infant mortality rate in the area
 22 involved.

23 (C) The percentage of the population in-
 24 volved with incomes below the poverty level.

1 (D) The percentage of the population in-
 2 volved age 65 or over.

3 The value of each of such variables for the service
 4 area involved shall be converted by the Secretary to
 5 a weighted value, according to established criteria,
 6 and added together to obtain the area's IMU score.

7 (d) PATIENT-CENTERED MEDICAL HOME.—

8 (1) IN GENERAL.—In this title, the term “pa-
 9 tient-centered medical home” means a physician-di-
 10 rected practice (or a nurse practitioner directed
 11 practice in those States in which such functions are
 12 included in the scope of practice of licensed nurse
 13 practitioners) that has been certified by an organiza-
 14 tion under paragraph (3) as meeting the following
 15 standards:

16 (A) The practice provides patients who
 17 elect to obtain care through a patient-centered
 18 medical home (referred to as “participating pa-
 19 tients”) with direct and ongoing access to a pri-
 20 mary or principal care physician or a primary
 21 care provider who accepts responsibility for pro-
 22 viding first contact, continuous, and comprehen-
 23 sive care to the whole person, in collaboration
 24 with teams of other health professionals, includ-

ing nurses and specialist physicians, as needed
and appropriate.

(B) The practice applies standards for access to care and communication with participating beneficiaries.

(C) The practice has readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically.

(D) The practice maintains continuous relationships with participating patients by implementing evidence-based guidelines and applying such guidelines to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries.

(2) RECOGNITION OF NCQA APPROVAL.—Such term also includes a physician-directed (or nurse-practitioner-directed) practice that has been recognized as a medical home through the Physician Practice Connections—patient-centered Medical Home (“PPC–PCMH”) voluntary recognition process of the National Committee for Quality Assurance.

(3) STANDARD SETTING AND QUALIFICATION PROCESS FOR MEDICAL HOMES.—The Secretary

1 shall establish a process for the selection of a quali-
2 fied standard setting and certification organiza-
3 tion—

4 (A) to establish standards, consistent with
5 this subsection, to enable medical practices to
6 qualify as patient-centered medical homes; and

7 (B) to provide for the review and certifi-
8 cation of medical practices as meeting such
9 standards.

10 (4) TREATMENT OF CERTAIN PRACTICES.—

11 Nothing in this section shall be construed as pre-
12 venting a nurse practitioner from leading a patient-
13 centered medical home so long as—

14 (A) all of the requirements of this section
15 are met; and

16 (B) the nurse practitioner is acting con-
17 sistently with State law.

18 (e) APPLICATION UNDER MEDICARE, MEDICAID,
19 PHSA, ETC.—Unless otherwise provided, the provisions of
20 the previous subsections shall apply for purposes of provi-
21 sions of the Social Security Act, the Public Health Service
22 Act, and any other Act amended by this title.

Title VII of the Higher Education Act of 1965 (20
U.S.C. 1133 et seq.) is amended by adding at the end
the following:

8 "SEC. 786. MEDICAL EDUCATION RECRUITMENT INCEN-
9 TIVES.

15 “(b) APPLICATION.—A graduate medical school that
16 desires to receive a grant under this section shall submit
17 to the Secretary an application at such time, in such man-
18 ner, and containing such information as the Secretary may
19 require.

23 “(1) The creation of primary care mentorship
24 programs.

1 “(2) Curriculum development for population-
2 based primary care models of care, such as the pa-
3 tient-centered medical home.

4 “(3) Increased opportunities for ambulatory,
5 community-based training.

6 “(4) Development of generalist curriculum to
7 enhance care for rural and underserved populations
8 in primary care or general surgery.

9 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
10 is authorized to be appropriated to carry out this section
11 \$50,000,000 for each of the fiscal years 2010 through
12 2012.”.

13 **SEC. 2102. DEBT FORGIVENESS, SCHOLARSHIPS, AND SERV-**
14 **ICE OBLIGATIONS.**

15 (a) PURPOSE.—It is the purpose of this section to
16 encourage individuals to enter and continue in primary
17 care physician careers.

18 (b) AMENDMENT TO THE PUBLIC HEALTH SERVICE
19 ACT.—Part D of title III of the Public Health Service Act
20 (42 U.S.C. 254b et seq.) is amended by adding at the end
21 the following:

22 **“Subpart XX—Primary Care Medical Education**

23 **“SEC. 340A. SCHOLARSHIPS.**

24 “(a) IN GENERAL.—The Secretary, acting through
25 the Administrator of the Health Resources and Services

1 Administration, shall award grants to critical shortage
2 health facilities to enable such facilities to provide scholar-
3 ships to individuals who agree to serve as physicians at
4 such facilities after completing a residency in a primary
5 care field (as defined in section 3(a)(5) of the Preserving
6 Patient Access to Primary Care Act of 2009).

7 “(b) SCHOLARSHIPS.—A health facility shall use
8 amounts received under a grant under this section to enter
9 into contracts with eligible individuals under which—

10 “(1) the facility agrees to provide the individual
11 with a scholarship for each school year (not to ex-
12 ceed 4 school years) in which the individual is en-
13 rolled as a full-time student in a school of medicine
14 or a school of osteopathic medicine; and

15 “(2) the individual agrees—

16 “(A) to maintain an acceptable level of
17 academic standing;

18 “(B) to complete a residency in a primary
19 care field; and

20 “(C) after completing the residency, to
21 serve as a primary care physician at such facil-
22 ity in such field for a time period equal to the
23 greater of—

1 “(i) one year for each school year for
2 which the individual was provided a schol-
3 arship under this section; or

4 “(ii) two years.

5 “(c) AMOUNT.—

6 “(1) IN GENERAL.—The amount paid by a
7 health facility to an individual under a scholarship
8 under this section shall not exceed \$35,000 for any
9 school year.

10 “(2) CONSIDERATIONS.—In determining the
11 amount of a scholarship to be provided to an indi-
12 vidual under this section, a health facility may take
13 into consideration the individual’s financial need, ge-
14 ographic differences, and educational costs.

15 “(3) EXCLUSION FROM GROSS INCOME.—For
16 purposes of the Internal Revenue Code of 1986,
17 gross income shall not include any amount received
18 as a scholarship under this section.

19 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
20 provisions of subpart III of part D shall, except as incon-
21 sistent with this section, apply to the program established
22 in subsection (a) in the same manner and to the same
23 extent as such provisions apply to the National Health
24 Service Corps Scholarship Program established in such
25 subpart.

1 “(e) DEFINITIONS.—In this section:

2 “(1) CRITICAL SHORTAGE HEALTH FACILITY.—

3 The term ‘critical shortage health facility’ means a
4 public or private nonprofit health facility that does
5 not serve a health professional shortage area (as
6 designated under section 332), but has a critical
7 shortage of physicians (as determined by the Sec-
8 retary) in a primary care field.

9 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
10 individual’ means an individual who is enrolled, or
11 accepted for enrollment, as a full-time student in an
12 accredited school of medicine or school of osteo-
13 pathic medicine.

14 **“SEC. 340B. LOAN REPAYMENT PROGRAM.**

15 “(a) PURPOSE.—It is the purpose of this section to
16 alleviate critical shortages of primary care physicians and
17 primary care providers.

18 “(b) LOAN REPAYMENTS.—The Secretary, acting
19 through the Administrator of the Health Resources and
20 Services Administration, shall establish a program of en-
21 tering into contracts with eligible individuals under
22 which—

23 “(1) the individual agrees to serve—

24 “(A) as a primary care physician or pri-
25 mary care provider in a primary care field; and

1 “(B) in an area that is not a health profes-
2 sional shortage area (as designated under sec-
3 tion 332), but has a critical shortage of primary
4 care physicians and primary care providers (as
5 determined by the Secretary) in such field; and

6 “(2) the Secretary agrees to pay, for each year
7 of such service, not more than \$35,000 of the prin-
8 cipal and interest of the undergraduate or graduate
9 educational loans of the individual.

10 “(c) SERVICE REQUIREMENT.—A contract entered
11 into under this section shall allow the individual receiving
12 the loan repayment to satisfy the service requirement de-
13 scribed in subsection (a)(1) through employment in a solo
14 or group practice, a clinic, a public or private nonprofit
15 hospital, or any other appropriate health care entity.

16 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
17 provisions of subpart III of part D shall, except as incon-
18 sistent with this section, apply to the program established
19 in subsection (a) in the same manner and to the same
20 extent as such provisions apply to the National Health
21 Service Corps Scholarship Program established in such
22 subpart.

23 “(e) DEFINITION.—In this section, the term ‘eligible
24 individual’ means—

1 “(1) an individual with a degree in medicine or
2 osteopathic medicine; or

3 “(2) a primary care provider (as defined in sec-
4 tion 3(a)(7) of the Preserving Patient Access to Pri-
5 mary Care Act of 2009).

6 **“SEC. 340C. LOAN REPAYMENTS FOR PHYSICIANS IN THE**
7 **FIELDS OF OBSTETRICS AND GYNECOLOGY**
8 **AND CERTIFIED NURSE MIDWIVES.**

9 “(a) PURPOSE.—It is the purpose of this section to
10 alleviate critical shortages of physicians in the fields of
11 obstetrics and gynecology and certified nurse midwives.

12 “(b) LOAN REPAYMENTS.—The Secretary, acting
13 through the Administrator of the Health Resources and
14 Services Administration, shall establish a program of en-
15 tering into contracts with eligible individuals under
16 which—

17 “(1) the individual agrees to serve—

18 “(A) as a physician in the field of obstet-
19 rics and gynecology or as a certified nurse mid-
20 wife; and

21 “(B) in an area that is not a health profes-
22 sional shortage area (as designated under sec-
23 tion 332), but has a critical shortage of physi-
24 cians in the fields of obstetrics and gynecology

1 or certified nurse midwives (as determined by
2 the Secretary), respectively; and

3 “(2) the Secretary agrees to pay, for each year
4 of such service, not more than \$35,000 of the prin-
5 cipal and interest of the undergraduate or graduate
6 educational loans of the individual.

7 “(c) SERVICE REQUIREMENT.—A contract entered
8 into under this section shall allow the individual receiving
9 the loan repayment to satisfy the service requirement de-
10 scribed in subsection (a)(1) through employment in a solo
11 or group practice, a clinic, a public or private nonprofit
12 hospital, or any other appropriate health care entity.

13 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
14 provisions of subpart III of part D shall, except as incon-
15 sistent with this section, apply to the program established
16 in subsection (a) in the same manner and to the same
17 extent as such provisions apply to the National Health
18 Service Corps Scholarship Program established in such
19 subpart.

20 “(e) DEFINITION.—In this section, the term ‘eligible
21 individual’ means—

22 “(1) a physician in the field of obstetrics and
23 gynecology; or

24 “(2) a certified nurse midwife.

1 **“SEC. 340D. REPORTS.**

2 “Not later than 18 months after the date of enact-
3 ment of this section, and annually thereafter, the Sec-
4 retary shall submit to Congress a report that describes
5 the programs carried out under this subpart, including
6 statements concerning—

7 “(1) the number of enrollees, scholarships, loan
8 repayments, and grant recipients;

9 “(2) the number of graduates;

10 “(3) the amount of scholarship payments and
11 loan repayments made;

12 “(4) which educational institution the recipients
13 attended;

14 “(5) the number and placement location of the
15 scholarship and loan repayment recipients at health
16 care facilities with a critical shortage of primary
17 care physicians;

18 “(6) the default rate and actions required;

19 “(7) the amount of outstanding default funds of
20 both the scholarship and loan repayment programs;

21 “(8) to the extent that it can be determined,
22 the reason for the default;

23 “(9) the demographics of the individuals par-
24 ticipating in the scholarship and loan repayment
25 programs;

1 “(10) the justification for the allocation of
2 funds between the scholarship and loan repayment
3 programs; and

4 “(11) an evaluation of the overall costs and
5 benefits of the programs.

6 **“SEC. 340E. AUTHORIZATION OF APPROPRIATIONS.**

7 “To carry out sections 340I, 340J, and 340K there
8 are authorized to be appropriated \$55,000,000 for fiscal
9 year 2010, \$90,000,000 for fiscal year 2011, and
10 \$125,000,000 for fiscal year 2012, to be used solely for
11 scholarships and loan repayment awards for primary care
12 physicians and primary care providers.”.

13 **SEC. 2103. DEFERMENT OF LOANS DURING RESIDENCY AND**
14 **INTERNSHIPS.**

15 (a) LOAN REQUIREMENTS.—Section 427(a)(2)(C)(i)
16 of the Higher Education Act of 1965 (20 U.S.C.
17 1077(a)(2)(C)(i)) is amended by inserting “unless the
18 medical internship or residency program is in a primary
19 care field (as defined in section 3(a)(5) of the Preserving
20 Patient Access to Primary Care Act of 2009)” after “resi-
21 dency program”.

22 (b) FFEL LOANS.—Section 428(b)(1)(M)(i) of the
23 Higher Education Act of 1965 (20 U.S.C.
24 1078(b)(1)(M)(i)) is amended by inserting “unless the
25 medical internship or residency program is in a primary

1 care field (as defined in section 3(a)(5) of the Preserving
 2 Patient Access to Primary Care Act of 2009)” after “resi-
 3 dency program”.

4 (c) FEDERAL DIRECT LOANS.—Section 455(f)(2)(A)
 5 of the Higher Education Act of 1965 (20 U.S.C.
 6 1087e(f)(2)(A)) is amended by inserting “unless the med-
 7 ical internship or residency program is in a primary care
 8 field (as defined in section 3(a)(5) of the Preserving Pa-
 9 tient Access to Primary Care Act of 2009)” after “resi-
 10 dency program”.

11 (d) FEDERAL PERKINS LOANS.—Section
 12 464(c)(2)(A)(i) of the Higher Education Act of 1965 (20
 13 U.S.C. 1087dd(c)(2)(A)(i)) is amended by inserting “un-
 14 less the medical internship or residency program is in a
 15 primary care field (as defined in section 3(a)(5) of the
 16 Preserving Patient Access to Primary Care Act of 2009)”
 17 after “residency program”.

18 **SEC. 2104. EDUCATING MEDICAL STUDENTS ABOUT PRI-**
 19 **MARY CARE CAREERS.**

20 Part C of title VII of the Public Health Service Act
 21 (42 U.S.C. 293k) is amended by adding at the end the
 22 following:

1 **“SEC. 749. EDUCATING MEDICAL STUDENTS ABOUT PRI-**
 2 **MARY CARE CAREERS.**

3 “(a) IN GENERAL.—The Secretary shall award
 4 grants to eligible State and local government entities for
 5 the development of informational materials that promote
 6 careers in primary care by highlighting the advantages
 7 and rewards of primary care, and that encourage medical
 8 students, particularly students from disadvantaged back-
 9 grounds, to become primary care physicians.

10 “(b) ANNOUNCEMENT.—The grants described in sub-
 11 section (a) shall be announced through a publication in
 12 the Federal Register and through appropriate media out-
 13 lets in a manner intended to reach medical education insti-
 14 tutions, associations, physician groups, and others who
 15 communicate with medical students.

16 “(c) ELIGIBILITY.—To be eligible to receive a grant
 17 under this section an entity shall—

18 “(1) be a State or local entity; and

19 “(2) submit to the Secretary an application at
 20 such time, in such manner, and containing such in-
 21 formation as the Secretary may require.

22 “(d) USE OF FUNDS.—

23 “(1) IN GENERAL.—An entity shall use
 24 amounts received under a grant under this section to
 25 support State and local campaigns through appro-
 26 priate media outlets to promote careers in primary

1 care and to encourage individuals from disadvan-
 2 taged backgrounds to enter and pursue careers in
 3 primary care.

4 “(2) SPECIFIC USES.—In carrying out activities
 5 under paragraph (1), an entity shall use grants
 6 funds to develop informational materials in a man-
 7 ner intended to reach as wide and diverse an audi-
 8 ence of medical students as possible, in order to—

9 “(A) advertise and promote careers in pri-
 10 mary care;

11 “(B) promote primary care medical edu-
 12 cation programs;

13 “(C) inform the public of financial assist-
 14 ance regarding such education programs;

15 “(D) highlight individuals in the commu-
 16 nity who are practicing primary care physicians;
 17 or

18 “(E) provide any other information to re-
 19 cruit individuals for careers in primary care.

20 “(e) LIMITATION.—An entity shall not use amounts
 21 received under a grant under this section to advertise par-
 22 ticular employment opportunities.

23 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
 24 is authorized to be appropriated to carry out this section,

1 such sums as may be necessary for each of fiscal years
 2 2010 through 2013.”.

3 **SEC. 2105. TRAINING IN FAMILY MEDICINE, GENERAL IN-**
 4 **TERNAL MEDICINE, GENERAL GERIATRICS,**
 5 **GENERAL PEDIATRICS, PHYSICIAN ASSIST-**
 6 **ANT EDUCATION, GENERAL DENTISTRY, AND**
 7 **PEDIATRIC DENTISTRY.**

8 Section 747(e) of the Public Health Service Act (42
 9 U.S.C. 293k) is amended by striking paragraph (1) and
 10 inserting the following:

11 “(1) AUTHORIZATION OF APPROPRIATIONS.—
 12 For the purpose of carrying out this section, there
 13 is authorized to be appropriated \$198,000,000 for
 14 each of fiscal years 2010 through 2012.”.

15 **SEC. 2106. INCREASED FUNDING FOR NATIONAL HEALTH**
 16 **SERVICE CORPS SCHOLARSHIP AND LOAN**
 17 **REPAYMENT PROGRAMS.**

18 (a) IN GENERAL.—There is authorized to be appro-
 19 priated \$332,000,000 for the period of fiscal years 2010
 20 through 2012 for the purpose of carrying out subpart III
 21 of part D of title III of the Public Health Service Act
 22 (42 U.S.C. 254l et seq.). Such authorization of appropria-
 23 tions is in addition to the authorization of appropriations
 24 in section 338H of such Act (42 U.S.C. 254q) and any
 25 other authorization of appropriations for such purpose.

1 (b) ALLOCATION.—Of the amounts appropriated
 2 under subsection (a) for the period of fiscal years 2010
 3 through 2012, the Secretary shall obligate \$96,000,000
 4 for the purpose of providing contracts for scholarships and
 5 loan repayments to individuals who—

6 (1) are primary care physicians or primary care
 7 providers; and

8 (2) have not previously received a scholarship or
 9 loan repayment under subpart III of part D of title
 10 III of the Public Health Service Act (42 U.S.C. 254l
 11 et seq.).

12 **Subtitle B—Medicaid Related** 13 **Provisions**

14 **SEC. 2201. TRANSFORMATION GRANTS TO SUPPORT PA-** 15 **TIENT-CENTERED MEDICAL HOMES UNDER** 16 **MEDICAID AND CHIP.**

17 (a) IN GENERAL.—Section 1903(z) of the Social Se-
 18 curity Act (42 U.S.C. 1396b(z)) is amended—

19 (1) in paragraph (2), by adding at the end the
 20 following new subparagraph:

21 “(G) Methods for improving the effective-
 22 ness and efficiency of medical assistance pro-
 23 vided under this title and child health assist-
 24 ance provided under title XXI by encouraging
 25 the adoption of medical practices that satisfy

the standards established by the Secretary under paragraph (2) of section 3(d) of the Preserving Patient Access to Primary Care Act of 2009 for medical practices to qualify as patient-centered medical homes (as defined in paragraph (1) of such section).”; and

(2) in paragraph (4)—

(A) in subparagraph (A)—

(i) in clause (i), by striking “and” at the end;

(ii) in clause (ii), by striking the period at the end and inserting “; and”; and

(iii) by inserting after clause (ii), the following new clause:

“(iii) \$25,000,000 for each of fiscal years 2010, 2011, and 2012.”; and

(B) in subparagraph (B), by striking the second and third sentences and inserting the following: “Such method shall provide that 100 percent of such funds for each of fiscal years 2010, 2011, and 2012 shall be allocated among States that design programs to adopt the innovative methods described in paragraph (2)(G), with preference given to States that design programs involving multipayers (including under

1 title XVIII and private health plans) test
 2 projects for implementation of the elements nec-
 3 essary to be recognized as a patient-centered
 4 medical home practice under the National Com-
 5 mittee for Quality Assurance Physicians Prac-
 6 tice Connection—PCMH module (or any other
 7 equivalent process, as determined by the Sec-
 8 retary).”.

9 (b) EFFECTIVE DATE.—The amendments made by
 10 this section take effect on October 1, 2010.

11 **Subtitle C—Medicare Provisions**

12 **PART I—PRIMARY CARE**

13 **SEC. 2301. REFORMING PAYMENT SYSTEMS UNDER MEDI-** 14 **CARE TO SUPPORT PRIMARY CARE.**

15 (a) INCREASING BUDGET NEUTRALITY LIMITS
 16 UNDER THE PHYSICIAN FEE SCHEDULE TO ACCOUNT
 17 FOR ANTICIPATED SAVINGS RESULTING FROM PAYMENTS
 18 FOR CERTAIN SERVICES AND THE COORDINATION OF
 19 BENEFICIARY CARE.—Section 1848(c)(2)(B) of the Social
 20 Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended—

21 (1) in clause (ii)(II), by striking “(iv) and (v)”
 22 and inserting “(iv), (v), and (vii)”; and

23 (2) by adding at the end the following new
 24 clause:

1 “(vii) INCREASE IN LIMITATION TO
2 ACCOUNT FOR CERTAIN ANTICIPATED SAV-
3 INGS.—

4 “(I) IN GENERAL.—Effective for
5 fee schedules established beginning
6 with 2010, the Secretary shall in-
7 crease the limitation on annual ad-
8 justments under clause (ii)(II) by an
9 amount equal to the anticipated sav-
10 ings under parts A, B, and D (includ-
11 ing any savings with respect to items
12 and services for which payment is not
13 made under this section) which are a
14 result of payments for designated pri-
15 mary care services and comprehensive
16 care coordination services under sec-
17 tion 1834(m) and the coverage of pa-
18 tient-centered medical home services
19 under section 1861(s)(2)(FF) (as de-
20 termined by the Secretary).

21 “(II) MECHANISM TO DETER-
22 MINE APPLICATION OF INCREASE.—
23 The Secretary shall establish a mecha-
24 nism for determining which relative
25 value units established under this

paragraph for physicians' services shall be subject to an adjustment under clause (ii)(I) as a result of the increase under subclause (I).

“(III) ADDITIONAL FUNDING AS DETERMINED NECESSARY BY THE SECRETARY.—In addition to any funding that may be made available as a result of an increase in the limitation on annual adjustments under subclause (I), there shall also be available to the Secretary, for purposes of making payments under this title for new services and capabilities to improve care provided to individuals under this title and to generate efficiencies under this title, such additional funds as the Secretary determines are necessary.”.

(b) SEPARATE MEDICARE PAYMENT FOR DESIGNATED PRIMARY CARE SERVICES AND COMPREHENSIVE CARE COORDINATION SERVICES.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

1 “(n) PAYMENT FOR DESIGNATED PRIMARY CARE
 2 SERVICES AND COMPREHENSIVE CARE COORDINATION
 3 SERVICES.—

4 “(1) IN GENERAL.—The Secretary shall pay for
 5 designated primary care services and comprehensive
 6 care coordination services furnished to an individual
 7 enrolled under this part.

8 “(2) PAYMENT AMOUNT.—The Secretary shall
 9 determine the amount of payment for designated
 10 primary care services and comprehensive care co-
 11 ordination services under this subsection.

12 “(3) DOCUMENTATION REQUIREMENTS.—The
 13 Secretary shall propose appropriate documentation
 14 requirements to justify payments for designated pri-
 15 mary care services and comprehensive care coordina-
 16 tion services under this subsection.

17 “(4) DEFINITIONS.—

18 “(A) COMPREHENSIVE CARE COORDINA-
 19 TION SERVICES.—The term ‘comprehensive care
 20 coordination services’ means care coordination
 21 services with procedure codes established by the
 22 Secretary (as appropriate) which are furnished
 23 to an individual enrolled under this part by a
 24 primary care provider or principal care physi-
 25 cian.

1 “(B) DESIGNATED PRIMARY CARE SERV-
2 ICES.—The term ‘designated primary care serv-
3 ice’ means a service which the Secretary deter-
4 mines has a procedure code which involves a
5 clinical interaction with an individual enrolled
6 under this part that is inherent to care coordi-
7 nation, including interactions outside of a face-
8 to-face encounter. Such term includes the fol-
9 lowing:

10 “(i) Care plan oversight.

11 “(ii) Evaluation and management pro-
12 vided by phone.

13 “(iii) Evaluation and management
14 provided using internet resources.

15 “(iv) Collection and review of physio-
16 logic data, such as from a remote moni-
17 toring device.

18 “(v) Education and training for pa-
19 tient self management.

20 “(vi) Anticoagulation management
21 services.

22 “(vii) Any other service determined
23 appropriate by the Secretary.”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by this section shall apply to items and services fur-
3 nished on or after January 1, 2010.

4 **SEC. 2302. COVERAGE OF PATIENT-CENTERED MEDICAL**
5 **HOME SERVICES.**

6 (a) IN GENERAL.—Section 1861(s)(2) of the Social
7 Security Act (42 U.S.C. 1395x(s)(2)) is amended—

8 (1) in subparagraph (DD), by striking “and” at
9 the end;

10 (2) in subparagraph (EE), by inserting “and”
11 at the end; and

12 (3) by adding at the end the following new sub-
13 paragraph:

14 “(FF) patient-centered medical home services
15 (as defined in subsection (hhh)(1));”.

16 (b) DEFINITION OF PATIENT-CENTERED MEDICAL
17 HOME SERVICES.—Section 1861 of the Social Security
18 Act (42 U.S.C. 1395x) is amended by adding at the end
19 the following new subsection:

20 “Patient-Centered Medical Home Services

21 “(hhh)(1) The term ‘patient-centered medical home
22 services’ means care coordination services furnished by a
23 qualified patient-centered medical home.

24 “(2) The term ‘qualified patient-centered medical
25 home’ means a patient-centered medical home (as defined

1 in section 3(d) of the Preserving Patient Access to Pri-
 2 mary Care Act of 2009).”.

3 (c) MONTHLY FEE FOR PATIENT-CENTERED MED-
 4 ICAL HOME SERVICES.—Section 1848 of the Social Secu-
 5 rity Act (42 U.S.C. 1395w–4) is amended by adding at
 6 the end the following new subsection:

7 “(p) MONTHLY FEE FOR PATIENT-CENTERED MED-
 8 ICAL HOME SERVICES.—

9 “(1) MONTHLY FEE.—

10 “(A) IN GENERAL.—Not later than Janu-
 11 ary 1, 2012, the Secretary shall establish a pay-
 12 ment methodology for patient-centered medical
 13 home services (as defined in paragraph (1) of
 14 section 1861(hhh)). Under such payment meth-
 15 odology, the Secretary shall pay qualified pa-
 16 tient-centered medical homes (as defined in
 17 paragraph (2) of such section) a monthly fee
 18 for each individual who elects to receive patient-
 19 centered medical home services at that medical
 20 home. Such fee shall be paid on a prospective
 21 basis.

22 “(B) CONSIDERATIONS.—The Secretary
 23 shall take into account the results of the Medi-
 24 care medical home demonstration project under
 25 section 204 of the Medicare Improvement and

1 Extension Act of 2006 (42 U.S.C. 1395b–1
2 note; division B of Public Law 109–432) in es-
3 tablishing the payment methodology under sub-
4 paragraph (A).

5 “(2) AMOUNT OF PAYMENT.—

6 “(A) CONSIDERATIONS.—In determining
7 the amount of such fee, subject to paragraph
8 (3), the Secretary shall consider the following:

9 “(i) The clinical work and practice ex-
10 penses involved in providing care coordina-
11 tion services consistent with the patient-
12 centered medical home model (such as pro-
13 viding increased access, care coordination,
14 disease population management, and edu-
15 cation) for which payment is not made
16 under this section as of the date of enact-
17 ment of this subsection.

18 “(ii) Ensuring that the amount of
19 payment is sufficient to support the acqui-
20 sition, use, and maintenance of clinical in-
21 formation systems which—

22 “(I) are needed by a qualified pa-
23 tient-centered medical home; and

1 “(II) have been shown to facili-
2 tate improved outcomes through care
3 coordination.

4 “(iii) The establishment of a tiered
5 monthly care management fee that pro-
6 vides for a range of payment depending on
7 how advanced the capabilities of a qualified
8 patient-centered medical home are in hav-
9 ing the information systems needed to sup-
10 port care coordination.

11 “(B) RISK-ADJUSTMENT.—The Secretary
12 shall use appropriate risk-adjustment in deter-
13 mining the amount of the monthly fee under
14 this paragraph.

15 “(3) FUNDING.—

16 “(A) IN GENERAL.—The Secretary shall
17 determine the aggregate estimated savings for a
18 calendar year as a result of the implementation
19 of this subsection on reducing preventable hos-
20 pital admissions, duplicate testing, medication
21 errors and drug interactions, and other savings
22 under this part and part A (including any sav-
23 ings with respect to items and services for
24 which payment is not made under this section).

1 “(B) FUNDING.—Subject to subparagraph
2 (C), the aggregate amount available for pay-
3 ment of the monthly fee under this subsection
4 during a calendar year shall be equal to the ag-
5 gregate estimated savings (as determined under
6 subparagraph (A)) for the calendar year (as de-
7 termined by the Secretary).

8 “(C) ADDITIONAL FUNDING.—In the case
9 where the amount of the aggregate actual sav-
10 ings during the preceding 3 years exceeds the
11 amount of the aggregate estimated savings (as
12 determined under subparagraph (A)) during
13 such period, the aggregate amount available for
14 payment of the monthly fee under this sub-
15 section during the calendar year (as determined
16 under subparagraph (B)) shall be increased by
17 the amount of such excess.

18 “(D) ADDITIONAL FUNDING AS DETER-
19 MINED NECESSARY BY THE SECRETARY.—In
20 addition to any funding made available under
21 subparagraphs (B) and (C), there shall also be
22 available to the Secretary, for purposes of effec-
23 tively implementing this subsection, such addi-
24 tional funds as the Secretary determines are
25 necessary.

1 “(4) PERFORMANCE-BASED BONUS PAY-
 2 MENTS.—The Secretary shall establish a process for
 3 paying a performance-based bonus to qualified pa-
 4 tient-centered medical homes which meet or achieve
 5 substantial improvements in performance (as speci-
 6 fied under clinical, patient satisfaction, and effi-
 7 ciency benchmarks established by the Secretary).
 8 Such bonus shall be in an amount determined appro-
 9 priate by the Secretary.

10 “(5) NO EFFECT ON PAYMENTS FOR EVALUA-
 11 TION AND MANAGEMENT SERVICES.—The monthly
 12 fee under this subsection shall have no effect on the
 13 amount of payment for evaluation and management
 14 services under this title.”.

15 (d) COINSURANCE.—Section 1833(a)(1) of the Social
 16 Security Act (42 U.S.C. 1395l(a)(1)) is amended—

17 (1) by striking “and” before “(W)”;

18 (2) by inserting before the semicolon at the end
 19 the following: “, and (X) with respect to patient-cen-
 20 tered medical home services (as defined in section
 21 1861(hhh)(1)), the amount paid shall be (i) in the
 22 case of such services which are physicians’ services,
 23 the amount determined under subparagraph (N),
 24 and (ii) in the case of all other such services, 80 per-
 25 cent of the lesser of the actual charge for the service

1 or the amount determined under a fee schedule es-
 2 tablished by the Secretary for purposes of this sub-
 3 paragraph”.

4 (e) EFFECTIVE DATE.—The amendments made by
 5 this section shall apply to services furnished on or after
 6 January 1, 2012.

7 **SEC. 2303. MEDICARE PRIMARY CARE PAYMENT EQUITY**
 8 **AND ACCESS PROVISION.**

9 (a) IN GENERAL.—Section 1848 of the Social Secu-
 10 rity Act (42 U.S.C. 1395w–4), as amended by section
 11 2302(c), is amended by adding at the end the following
 12 new subsection:

13 “(q) PRIMARY CARE PAYMENT EQUITY AND AC-
 14 CESS.—

15 “(1) IN GENERAL.—Not later than January 1,
 16 2010, the Secretary shall develop a methodology, in
 17 consultation with primary care physician organiza-
 18 tions and primary care provider organizations, the
 19 Medicare Payment Advisory Commission, and other
 20 experts, to increase payments under this section for
 21 designated evaluation and management services pro-
 22 vided by primary care physicians, primary care pro-
 23 viders, and principal care providers through 1 or
 24 more of the following:

1 “(A) A service-specific modifier to the rel-
2 ative value units established for such services.

3 “(B) Service-specific bonus payments.

4 “(C) Any other methodology determined
5 appropriate by the Secretary.

6 “(2) INCLUSION OF PROPOSED CRITERIA.—The
7 methodology developed under paragraph (1) shall in-
8 clude proposed criteria for providers to qualify for
9 such increased payments, including consideration
10 of—

11 “(A) the type of service being rendered;

12 “(B) the specialty of the provider providing
13 the service; and

14 “(C) demonstration by the provider of vol-
15 untary participation in programs to improve
16 quality, such as participation in the Physician
17 Quality Reporting Initiative (as determined by
18 the Secretary) or practice-level qualification as
19 a patient-centered medical home.

20 “(3) FUNDING.—

21 “(A) DETERMINATION.—The Secretary
22 shall determine the aggregate estimated savings
23 for a calendar year as a result of such increased
24 payments on reducing preventable hospital ad-
25 missions, duplicate testing, medication errors

1 and drug interactions, Intensive Care Unit ad-
2 missions, per capita health care expenditures,
3 and other savings under this part and part A
4 (including any savings with respect to items
5 and services for which payment is not made
6 under this section).

7 “(B) FUNDING.—The aggregate amount
8 available for such increased payments during a
9 calendar year shall be equal to the aggregate
10 estimated savings (as determined under sub-
11 paragraph (A)) for the calendar year (as deter-
12 mined by the Secretary).

13 “(C) ADDITIONAL FUNDING AS DETER-
14 MINED NECESSARY BY THE SECRETARY.—In
15 addition to any funding made available under
16 subparagraph (B), there shall also be available
17 to the Secretary, for purposes of effectively im-
18 plementing this subsection, such additional
19 funds as the Secretary determines are nec-
20 essary.”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 this section shall apply to services furnished on or after
23 January 1, 2010.

1 **SEC. 2304. ADDITIONAL INCENTIVE PAYMENT PROGRAM**
 2 **FOR PRIMARY CARE SERVICES FURNISHED**
 3 **IN HEALTH PROFESSIONAL SHORTAGE**
 4 **AREAS.**

5 (a) IN GENERAL.—Section 1833 of the Social Secu-
 6 rity Act (42 U.S.C. 1395l) is amended by adding at the
 7 end the following new subsection:

8 “(x) ADDITIONAL INCENTIVE PAYMENTS FOR PRI-
 9 MARY CARE SERVICES FURNISHED IN HEALTH PROFES-
 10 SIONAL SHORTAGE AREAS.—

11 “(1) IN GENERAL.—In the case of primary care
 12 services furnished on or after January 1, 2010, by
 13 a primary care physician or primary care provider in
 14 an area that is designated (under section
 15 332(a)(1)(A) of the Public Health Service Act) as a
 16 health professional shortage area as identified by the
 17 Secretary prior to the beginning of the year involved,
 18 in addition to the amount of payment that would
 19 otherwise be made for such services under this part,
 20 there also shall be paid (on a monthly or quarterly
 21 basis) an amount equal to 10 percent of the pay-
 22 ment amount for the service under this part.

23 “(2) DEFINITIONS.—In this subsection:

24 “(A) PRIMARY CARE PHYSICIAN; PRIMARY
 25 CARE PROVIDER.—The terms ‘primary care
 26 physician’ and ‘primary care provider’ have the

1 meaning given such terms in paragraphs (6)
 2 and (7), respectively, of section 3(a) of the Pre-
 3 serving Patient Access to Primary Care Act of
 4 2009.

5 “(B) PRIMARY CARE SERVICES.—The term
 6 ‘primary care services’ means procedure codes
 7 for services in the category of the Healthcare
 8 Common Procedure Coding System, as estab-
 9 lished by the Secretary under section
 10 1848(c)(5) (as of December 31, 2008, and as
 11 subsequently modified by the Secretary) con-
 12 sisting of evaluation and management services,
 13 but limited to such procedure codes in the cat-
 14 egory of office or other outpatient services, and
 15 consisting of subcategories of such procedure
 16 codes for services for both new and established
 17 patients.

18 “(3) JUDICIAL REVIEW.—There shall be no ad-
 19 ministrative or judicial review under section 1869,
 20 1878, or otherwise, respecting the identification of
 21 primary care physicians, primary care providers, or
 22 primary care services under this subsection.”.

23 (b) CONFORMING AMENDMENT.—Section
 24 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
 25 1395m(g)(2)(B)) is amended by adding at the end the fol-

1 lowing sentence: “Section 1833(x) shall not be taken into
 2 account in determining the amounts that would otherwise
 3 be paid pursuant to the preceding sentence.”.

4 **SEC. 2305. PERMANENT EXTENSION OF MEDICARE INCEN-**
 5 **TIVE PAYMENT PROGRAM FOR PHYSICIAN**
 6 **SCARCITY AREAS.**

7 Section 1833(u) of the Social Security Act (42 U.S.C.
 8 1395l(u)) is amended—

9 (1) in paragraph (1)—

10 (A) by inserting “or on or after July 1,
 11 2009” after “before July 1, 2008”; and

12 (B) by inserting “(or, in the case of serv-
 13 ices furnished on or after July 1, 2009, 10 per-
 14 cent)” after “5 percent”; and

15 (2) in paragraph (4)(D), by striking “before
 16 July 1, 2008” and inserting “before January 1,
 17 2010”.

18 **SEC. 2306. HHS STUDY AND REPORT ON THE PROCESS FOR**
 19 **DETERMINING RELATIVE VALUE UNDER THE**
 20 **MEDICARE PHYSICIAN FEE SCHEDULE.**

21 (a) STUDY.—The Secretary shall conduct a study on
 22 the process used by the Secretary for determining relative
 23 value under the Medicare physician fee schedule under
 24 section 1848(c) of the Social Security Act (42 U.S.C.

1 1395w-4(c)). Such study shall include an analysis of the
2 following:

3 (1)(A) Whether the existing process includes
4 equitable representation of primary care physicians
5 (as defined in section 2003(a)(6)); and

6 (B) any changes that may be necessary to en-
7 sure such equitable representation.

8 (2)(A) Whether the existing process provides
9 the Secretary with expert and impartial input from
10 physicians in medical specialties that provide pri-
11 mary care to patients with multiple chronic diseases,
12 the fastest growing part of the Medicare population;
13 and

14 (B) any changes that may be necessary to en-
15 sure such input.

16 (3)(A) Whether the existing process includes
17 equitable representation of physician medical special-
18 ties in proportion to their relative contributions to-
19 ward caring for Medicare beneficiaries, as deter-
20 mined by the percentage of Medicare billings per
21 specialty, percentage of Medicare encounters by spe-
22 cialty, or such other measures of relative contribu-
23 tions to patient care as determined by the Secretary;
24 and

1 (B) any changes that may be necessary to re-
 2 flect such equitable representation.

3 (4)(A) Whether the existing process, including
 4 the application of budget neutrality rules, unfairly
 5 disadvantages primary care physicians, primary care
 6 providers, or other physicians who principally pro-
 7 vide evaluation and management services; and

8 (B) any changes that may be necessary to
 9 eliminate such disadvantages.

10 (b) REPORT.—Not later than 12 months after the
 11 date of enactment of this Act, the Secretary shall submit
 12 to Congress a report containing the results of the study
 13 conducted under subsection (a), together with rec-
 14 ommendations for such legislation and administrative ac-
 15 tion as the Secretary determines appropriate.

16 **PART II—PREVENTIVE SERVICES**

17 **SEC. 2311. ELIMINATING TIME RESTRICTION FOR INITIAL** 18 **PREVENTIVE PHYSICAL EXAMINATION.**

19 (a) IN GENERAL.—Section 1862(a)(1)(K) of the So-
 20 cial Security Act (42 U.S.C. 1395y(a)(1)(K)) is amended
 21 by striking “more than” and all that follows before the
 22 comma at the end and inserting “more than one time dur-
 23 ing the lifetime of the individual”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to services furnished on or after
 3 January 1, 2010.

4 **SEC. 2312. ELIMINATION OF COST-SHARING FOR PREVEN-**
 5 **TIVE BENEFITS UNDER THE MEDICARE PRO-**
 6 **GRAM.**

7 (a) DEFINITION OF PREVENTIVE SERVICES.—Sec-
 8 tion 1861(ddd) of the Social Security Act (42 U.S.C.
 9 1395w(dd)) is amended—

10 (1) in the heading, by inserting “; Preventive
 11 Services” after “Services”;

12 (2) in paragraph (1), by striking “not otherwise
 13 described in this title” and inserting “not described
 14 in subparagraphs (A) through (N) of paragraph
 15 (3)”; and

16 (3) by adding at the end the following new
 17 paragraph:

18 “(3) The term ‘preventive services’ means the fol-
 19 lowing:

20 “(A) Prostate cancer screening tests (as defined
 21 in subsection (oo)).

22 “(B) Colorectal cancer screening tests (as de-
 23 fined in subsection (pp)).

24 “(C) Diabetes outpatient self-management
 25 training services (as defined in subsection (qq)).

1 “(D) Screening for glaucoma for certain indi-
2 viduals (as described in subsection (s)(2)(U)).

3 “(E) Medical nutrition therapy services for cer-
4 tain individuals (as described in subsection
5 (s)(2)(V)).

6 “(F) An initial preventive physical examination
7 (as defined in subsection (ww)).

8 “(G) Cardiovascular screening blood tests (as
9 defined in subsection (xx)(1)).

10 “(H) Diabetes screening tests (as defined in
11 subsection (yy)).

12 “(I) Ultrasound screening for abdominal aortic
13 aneurysm for certain individuals (as described in
14 subsection (s)(2)(AA)).

15 “(J) Pneumococcal and influenza vaccine and
16 their administration (as described in subsection
17 (s)(10)(A)).

18 “(K) Hepatitis B vaccine and its administration
19 for certain individuals (as described in subsection
20 (s)(10)(B)).

21 “(L) Screening mammography (as defined in
22 subsection (jj)).

23 “(M) Screening pap smear and screening pelvic
24 exam (as described in subsection (s)(14)).

1 “(N) Bone mass measurement (as defined in
2 subsection (rr)).

3 “(O) Additional preventive services (as deter-
4 mined under paragraph (1)).”.

5 (b) COINSURANCE.—

6 (1) GENERAL APPLICATION.—

7 (A) IN GENERAL.—Section 1833(a)(1) of
8 the Social Security Act (42 U.S.C.
9 1395l(a)(1)), as amended by section 2302, is
10 amended—

11 (i) in subparagraph (T), by striking
12 “80 percent” and inserting “100 percent”;

13 (ii) in subparagraph (W), by striking
14 “80 percent” and inserting “100 percent”;

15 (iii) by striking “and” before “(X)”;

16 and

17 (iv) by inserting before the semicolon
18 at the end the following: “, and (Y) with
19 respect to preventive services described in
20 subparagraphs (A) through (O) of section
21 1861(ddd)(3), the amount paid shall be
22 100 percent of the lesser of the actual
23 charge for the services or the amount de-
24 termined under the fee schedule that ap-
25 plies to such services under this part”.

1 (2) ELIMINATION OF COINSURANCE FOR
 2 SCREENING SIGMOIDOSCOPIES AND
 3 COLONOSCOPIES.—Section 1834(d) of the Social Se-
 4 curity Act (42 U.S.C. 1395m(d)) is amended—

5 (A) in paragraph (2)—

6 (i) in subparagraph (A), by inserting
 7 “, except that payment for such tests
 8 under such section shall be 100 percent of
 9 the payment determined under such sec-
 10 tion for such tests” before the period at
 11 the end; and

12 (ii) in subparagraph (C)—

13 (I) by striking clause (ii); and

14 (II) in clause (i)—

15 (aa) by striking “(i) IN GEN-
 16 ERAL.—Notwithstanding” and
 17 inserting “Notwithstanding”;

18 (bb) by redesignating sub-
 19 clauses (I) and (II) as clauses (i)
 20 and (ii), respectively, and moving
 21 such clauses 2 ems to the left;
 22 and

23 (cc) in the flush matter fol-
 24 lowing clause (ii), as so redesign-

1 nated, by inserting “100 percent
2 of” after “based on”; and

3 (B) in paragraph (3)—

4 (i) in subparagraph (A), by inserting
5 “, except that payment for such tests
6 under such section shall be 100 percent of
7 the payment determined under such sec-
8 tion for such tests” before the period at
9 the end; and

10 (ii) in subparagraph (C)—

11 (I) by striking clause (ii); and

12 (II) in clause (i)—

13 (aa) by striking “(i) IN GEN-
14 ERAL.—Notwithstanding” and
15 inserting “Notwithstanding”; and

16 (bb) by inserting “100 per-
17 cent of” after “based on”.

18 (3) ELIMINATION OF COINSURANCE IN OUT-
19 PATIENT HOSPITAL SETTINGS.—

20 (A) EXCLUSION FROM OPD FEE SCHED-
21 ULE.—Section 1833(t)(1)(B)(iv) of the Social
22 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
23 amended by striking “and diagnostic mammog-
24 raphy” and inserting “, diagnostic mammog-

1 raphy, and preventive services (as defined in
2 section 1861(ddd)(3))”.

3 (B) CONFORMING AMENDMENTS.—Section
4 1833(a)(2) of the Social Security Act (42
5 U.S.C. 1395l(a)(2)) is amended—

6 (i) in subparagraph (F), by striking
7 “and” after the semicolon at the end;

8 (ii) in subparagraph (G)(ii), by adding
9 “and” at the end; and

10 (iii) by adding at the end the fol-
11 lowing new subparagraph:

12 “(H) with respect to preventive services (as
13 defined in section 1861(ddd)(3)) furnished by
14 an outpatient department of a hospital, the
15 amount determined under paragraph (1)(W) or
16 (1)(X), as applicable;”.

17 (c) WAIVER OF APPLICATION OF DEDUCTIBLE.—The
18 first sentence of section 1833(b) of the Social Security Act
19 (42 U.S.C. 1395l(b)) is amended—

20 (1) in clause (1), by striking “items and serv-
21 ices described in section 1861(s)(10)(A)” and insert-
22 ing “preventive services (as defined in section
23 1861(ddd)(3))”;

24 (2) by inserting “and” before “(4)”; and

1 (3) by striking “, (5)” and all that follows up
2 to the period at the end.

3 **SEC. 2313. HHS STUDY AND REPORT ON FACILITATING THE**
4 **RECEIPT OF MEDICARE PREVENTIVE SERV-**
5 **ICES BY MEDICARE BENEFICIARIES.**

6 (a) STUDY.—The Secretary, in consultation with pro-
7 vider organizations and other appropriate stakeholders,
8 shall conduct a study on—

9 (1) ways to assist primary care physicians and
10 primary care providers (as defined in section
11 2003(a)) in—

12 (A) furnishing appropriate preventive serv-
13 ices (as defined in section 1861(ddd)(3) of the
14 Social Security Act, as added by section 2312)
15 to individuals enrolled under part B of title
16 XVIII of such Act; and

17 (B) referring such individuals for other
18 items and services furnished by other physicians
19 and health care providers; and

20 (2) the advisability and feasibility of making
21 additional payments under the Medicare program to
22 physicians and primary care providers for—

23 (A) the work involved in ensuring that
24 such individuals receive appropriate preventive

1 services furnished by other physicians and
 2 health care providers; and

3 (B) incorporating the resulting clinical in-
 4 formation into the treatment plan for the indi-
 5 vidual.

6 (b) REPORT.—Not later than 12 months after the
 7 date of enactment of this Act, the Secretary shall submit
 8 to Congress a report containing the results of the study
 9 conducted under subsection (a), together with rec-
 10 ommendations for such legislation and administrative ac-
 11 tion as the Secretary determines appropriate.

12 **PART III—OTHER PROVISIONS**

13 **SEC. 2321. HHS STUDY AND REPORT ON IMPROVING THE** 14 **ABILITY OF PHYSICIANS AND PRIMARY CARE** 15 **PROVIDERS TO ASSIST MEDICARE BENE-** 16 **FICIARIES IN OBTAINING NEEDED PRESCRIP-** 17 **TIONS UNDER MEDICARE PART D.**

18 (a) STUDY.—The Secretary, in consultation with phy-
 19 sician organizations and other appropriate stakeholders,
 20 shall conduct a study on the development and implementa-
 21 tion of mechanisms to facilitate increased efficiency relat-
 22 ing to the role of physicians and primary care providers
 23 in Medicare beneficiaries obtaining needed prescription
 24 drugs under the Medicare prescription drug program

1 under part D of title XVIII of the Social Security Act.

2 Such study shall include an analysis of ways to—

3 (1) improve the accessibility of formulary infor-
4 mation;

5 (2) streamline the prior authorization, excep-
6 tion, and appeals processes, through, at a minimum,
7 standardizing formats and allowing electronic ex-
8 change of information; and

9 (3) recognize the work of the physician and pri-
10 mary care provider involved in the prescribing proc-
11 ess, especially work that may extend beyond the
12 amount considered to be bundled into payment for
13 evaluation and management services.

14 (b) REPORT.—Not later than 12 months after the
15 date of enactment of this Act, the Secretary shall submit
16 to Congress a report containing the results of the study
17 conducted under subsection (a), together with rec-
18 ommendations for such legislation and administrative ac-
19 tion as the Secretary determines appropriate.

20 **SEC. 2322. HHS STUDY AND REPORT ON IMPROVED PA-**
21 **TIENT CARE THROUGH INCREASED CARE-**
22 **GIVER AND PHYSICIAN INTERACTION.**

23 (a) STUDY.—The Secretary, in consultation with ap-
24 propriate stakeholders, shall conduct a study on the devel-
25 opment and implementation of mechanisms to promote

1 and increase interaction between physicians or primary
 2 care providers and the families of Medicare beneficiaries,
 3 as well as other caregivers who support such beneficiaries,
 4 for the purpose of improving patient care under the Medi-
 5 care program. Such study shall include an analysis of—

6 (1) ways to recognize the work of physicians
 7 and primary care providers involved in discussing
 8 clinical issues with caregivers that relate to the care
 9 of the beneficiary; and

10 (2) regulations under the Medicare program
 11 that are barriers to interactions between caregivers
 12 and physicians or primary care providers and how
 13 such regulations should be revised to eliminate such
 14 barriers.

15 (b) REPORT.—Not later than 12 months after the
 16 date of enactment of this Act, the Secretary shall submit
 17 to Congress a report containing the results of the study
 18 conducted under subsection (a), together with rec-
 19 ommendations for such legislation and administrative ac-
 20 tion as the Secretary determines appropriate.

21 **SEC. 2323. IMPROVED PATIENT CARE THROUGH EXPANDED**
 22 **SUPPORT FOR LIMITED ENGLISH PRO-**
 23 **FICIENCY (LEP) SERVICES.**

24 (a) ADDITIONAL PAYMENTS FOR PRIMARY CARE
 25 PHYSICIANS AND PRIMARY CARE PROVIDERS.—Section

1 1833 of the Social Security Act (42 U.S.C. 1395l), as
 2 amended by section 2304, is amended by adding at the
 3 end the following new subsection:

4 “(y) ADDITIONAL PAYMENTS FOR PROVIDING SERV-
 5 ICES TO INDIVIDUALS WITH LIMITED ENGLISH PRO-
 6 FICIENCY.—

7 “(1) IN GENERAL.—In the case of primary care
 8 providers’ services furnished on or after January 1,
 9 2010, to an individual with limited English pro-
 10 ficiency by a provider, in addition to the amount of
 11 payment that would otherwise be made for such
 12 services under this part, there shall also be paid an
 13 appropriate amount (as determined by the Sec-
 14 retary) in order to recognize the additional time in-
 15 volved in furnishing the service to such individual.

16 “(2) JUDICIAL REVIEW.—There shall be no ad-
 17 ministrative or judicial review under section 1869,
 18 1878, or otherwise, respecting the determination of
 19 the amount of additional payment under this sub-
 20 section.”.

21 (b) NATIONAL CLEARINGHOUSE.—Not later than
 22 180 days after the date of enactment of this Act, the Sec-
 23 retary shall establish a national clearinghouse to make
 24 available to the primary care physicians, primary care pro-
 25 viders, patients, and States translated documents regard-

1 ing patient care and education under the Medicare pro-
 2 gram, the Medicaid program, and the State Children's
 3 Health Insurance Program under titles XVIII, XIX, and
 4 XXI, respectively, of the Social Security Act.

5 (c) GRANTS TO SUPPORT LANGUAGE TRANSLATION
 6 SERVICES IN UNDERSERVED COMMUNITIES.—

7 (1) AUTHORITY TO AWARD GRANTS.—The Sec-
 8 retary shall award grants to support language trans-
 9 lation services for primary care physicians and pri-
 10 mary care providers in medically underserved areas
 11 (as defined in section 2003(c)).

12 (2) AUTHORIZATION OF APPROPRIATIONS.—
 13 There are authorized to be appropriated to the Sec-
 14 retary to award grants under this subsection, such
 15 sums as are necessary for fiscal years beginning with
 16 fiscal year 2010.

17 **SEC. 2324. HHS STUDY AND REPORT ON USE OF REAL-TIME**
 18 **MEDICARE CLAIMS ADJUDICATION.**

19 (a) STUDY.—The Secretary shall conduct a study to
 20 assess the ability of the Medicare program under title
 21 XVIII of the Social Security Act to engage in real-time
 22 claims adjudication for items and services furnished to
 23 Medicare beneficiaries.

24 (b) CONSULTATION.—In conducting the study under
 25 subsection (a), the Secretary consult with stakeholders in

1 the private sector, including stakeholders who are using
2 or are testing real-time claims adjudication systems.

3 (c) REPORT.—Not later than January 1, 2011, the
4 Secretary shall submit to Congress a report containing the
5 results of the study conducted under subsection (a), to-
6 gether with recommendations for such legislation and ad-
7 ministrative action as the Secretary determines appro-
8 priate.

9 **SEC. 2325. ONGOING ASSESSMENT BY MEDPAC OF THE IM-**
10 **PACT OF MEDICARE PAYMENTS ON PRIMARY**
11 **CARE ACCESS AND EQUITY.**

12 The Medicare Payment Advisory Commission, begin-
13 ning in 2010 and in each of its subsequent annual reports
14 to Congress on Medicare physician payment policies, shall
15 provide an assessment of the impact of changes in Medi-
16 care payment policies in improving access to and equity
17 of payments to primary care physicians and primary care
18 providers. Such assessment shall include an assessment of
19 the effectiveness, once implemented, of the Medicare pay-
20 ment-related reforms required by this Act to support pri-
21 mary care as well as any other payment changes that may
22 be required by Congress to improve access to and equity
23 of payments to primary care physicians and primary care
24 providers.

1 **SEC. 2326. DISTRIBUTION OF ADDITIONAL RESIDENCY PO-**
 2 **SITIONS.**

3 (a) IN GENERAL.—Section 1886(h) of the Social Se-
 4 curity Act (42 U.S.C. 1395ww(h)) is amended—

5 (1) in paragraph (4)(F)(i), by striking “para-
 6 graph (7)” and inserting “paragraphs (7) and (8)”;

7 (2) in paragraph (4)(H)(i), by striking “para-
 8 graph (7)” and inserting “paragraphs (7) and (8)”;
 9 and

10 (3) by adding at the end the following new
 11 paragraph:

12 “(8) DISTRIBUTION OF ADDITIONAL RESIDENCY
 13 POSITIONS.—

14 “(A) ADDITIONAL RESIDENCY POSI-
 15 TIONS.—

16 “(i) REDUCTION IN LIMIT BASED ON
 17 UNUSED POSITIONS.—

18 “(I) IN GENERAL.—The Sec-
 19 retary shall reduce the otherwise ap-
 20 plicable resident limit for a hospital
 21 that the Secretary determines had
 22 residency positions that were unused
 23 for all 5 of the most recent cost re-
 24 porting periods ending prior to the
 25 date of enactment of this paragraph
 26 by an amount that is equal to the

1 number of such unused residency po-
2 sitions.

3 “(II) EXCEPTION FOR RURAL
4 HOSPITALS AND CERTAIN OTHER HOS-
5 PITALS.—This subparagraph shall not
6 apply to a hospital—

7 “(aa) located in a rural area
8 (as defined in subsection
9 (d)(2)(D)(ii));

10 “(bb) that has participated
11 in a voluntary reduction plan
12 under paragraph (6); or

13 “(cc) that has participated
14 in a demonstration project ap-
15 proved as of October 31, 2003,
16 under the authority of section
17 402 of Public Law 90–248.

18 “(ii) NUMBER AVAILABLE FOR DIS-
19 TRIBUTION.—The number of additional
20 residency positions available for distribu-
21 tion under subparagraph (B) shall be an
22 amount that the Secretary determines
23 would result in a 15 percent increase in
24 the aggregate number of full-time equiva-
25 lent residents in approved medical training

1 programs (as determined based on the
2 most recent cost reports available at the
3 time of distribution). One-third of such
4 number shall only be available for distribu-
5 tion to hospitals described in subclause (I)
6 of subparagraph (B)(ii) under such sub-
7 paragraph.

8 “(B) DISTRIBUTION.—

9 “(i) IN GENERAL.—The Secretary
10 shall increase the otherwise applicable resi-
11 dent limit for each qualifying hospital that
12 submits an application under this subpara-
13 graph by such number as the Secretary
14 may approve for portions of cost reporting
15 periods occurring on or after the date of
16 enactment of this paragraph. The aggre-
17 gate number of increases in the otherwise
18 applicable resident limit under this sub-
19 paragraph shall be equal to the number of
20 additional residency positions available for
21 distribution under subparagraph (A)(ii).

22 “(ii) DISTRIBUTION TO HOSPITALS
23 ALREADY OPERATING OVER RESIDENT
24 LIMIT.—

1 “(I) IN GENERAL.—Subject to
2 subclause (II), in the case of a hos-
3 pital in which the reference resident
4 level of the hospital (as defined in
5 clause (ii)) is greater than the other-
6 wise applicable resident limit, the in-
7 crease in the otherwise applicable resi-
8 dent limit under this subparagraph
9 shall be an amount equal to the prod-
10 uct of the total number of additional
11 residency positions available for dis-
12 tribution under subparagraph (A)(ii)
13 and the quotient of—

14 “(aa) the number of resident
15 positions by which the reference
16 resident level of the hospital ex-
17 ceeds the otherwise applicable
18 resident limit for the hospital;
19 and

20 “(bb) the number of resident
21 positions by which the reference
22 resident level of all such hospitals
23 with respect to which an applica-
24 tion is approved under this sub-
25 paragraph exceeds the otherwise

1 applicable resident limit for such
2 hospitals.

3 “(II) REQUIREMENTS.—A hos-
4 pital described in subclause (I)—

5 “(aa) is not eligible for an
6 increase in the otherwise applica-
7 ble resident limit under this sub-
8 paragraph unless the amount by
9 which the reference resident level
10 of the hospital exceeds the other-
11 wise applicable resident limit is
12 not less than 10 and the hospital
13 trains at least 25 percent of the
14 full-time equivalent residents of
15 the hospital in primary care and
16 general surgery (as of the date of
17 enactment of this paragraph);
18 and

19 “(bb) shall continue to train
20 at least 25 percent of the full-
21 time equivalent residents of the
22 hospital in primary care and gen-
23 eral surgery for the 10-year pe-
24 riod beginning on such date.

1 In the case where the Secretary deter-
 2 mines that a hospital no longer meets
 3 the requirement of item (bb), the Sec-
 4 retary may reduce the otherwise appli-
 5 cable resident limit of the hospital by
 6 the amount by which such limit was
 7 increased under this clause.

8 “(III) CLARIFICATION REGARD-
 9 ING ELIGIBILITY FOR OTHER ADDI-
 10 TIONAL RESIDENCY POSITIONS.—
 11 Nothing in this clause shall be con-
 12 strued as preventing a hospital de-
 13 scribed in subclause (I) from applying
 14 for additional residency positions
 15 under this paragraph that are not re-
 16 served for distribution under this
 17 clause.

18 “(iii) REFERENCE RESIDENT
 19 LEVEL.—

20 “(I) IN GENERAL.—Except as
 21 otherwise provided in subclause (II),
 22 the reference resident level specified in
 23 this clause for a hospital is the resi-
 24 dent level for the most recent cost re-
 25 porting period of the hospital ending

1 on or before the date of enactment of
2 this paragraph, for which a cost re-
3 port has been settled (or, if not, sub-
4 mitted (subject to audit)), as deter-
5 mined by the Secretary.

6 “(II) USE OF MOST RECENT AC-
7 COUNTING PERIOD TO RECOGNIZE EX-
8 PANSION OF EXISTING PROGRAM OR
9 ESTABLISHMENT OF NEW PRO-
10 GRAM.—If a hospital submits a timely
11 request to increase its resident level
12 due to an expansion of an existing
13 residency training program or the es-
14 tablishment of a new residency train-
15 ing program that is not reflected on
16 the most recent cost report that has
17 been settled (or, if not, submitted
18 (subject to audit)), after audit and
19 subject to the discretion of the Sec-
20 retary, the reference resident level for
21 such hospital is the resident level for
22 the cost reporting period that includes
23 the additional residents attributable to
24 such expansion or establishment, as
25 determined by the Secretary.

1 “(C) CONSIDERATIONS IN REDISTRIBU-
2 TION.—In determining for which hospitals the
3 increase in the otherwise applicable resident
4 limit is provided under subparagraph (B) (other
5 than an increase under subparagraph (B)(ii)),
6 the Secretary shall take into account the dem-
7 onstrated likelihood of the hospital filling the
8 positions within the first 3 cost reporting peri-
9 ods beginning on or after July 1, 2010, made
10 available under this paragraph, as determined
11 by the Secretary.

12 “(D) PRIORITY FOR CERTAIN AREAS.—In
13 determining for which hospitals the increase in
14 the otherwise applicable resident limit is pro-
15 vided under subparagraph (B) (other than an
16 increase under subparagraph (B)(ii)), the Sec-
17 retary shall distribute the increase to hospitals
18 based on the following criteria:

19 “(i) The Secretary shall give pref-
20 erence to hospitals that submit applica-
21 tions for new primary care and general
22 surgery residency positions. In the case of
23 any increase based on such preference, a
24 hospital shall ensure that—

1 “(I) the position made available
2 as a result of such increase remains a
3 primary care or general surgery resi-
4 dency position for not less than 10
5 years after the date on which the posi-
6 tion is filled; and

7 “(II) the total number of primary
8 care and general surgery residency po-
9 sitions in the hospital (determined
10 based on the number of such positions
11 as of the date of such increase, includ-
12 ing any position added as a result of
13 such increase) is not decreased during
14 such 10-year period.

15 In the case where the Secretary determines
16 that a hospital no longer meets the re-
17 quirement of subclause (II), the Secretary
18 may reduce the otherwise applicable resi-
19 dent limit of the hospital by the amount by
20 which such limit was increased under this
21 paragraph.

22 “(ii) The Secretary shall give pref-
23 erence to hospitals that emphasizes train-
24 ing in community health centers and other
25 community-based clinical settings.

“(iii) The Secretary shall give preference to hospitals in States that have more medical students than residency positions available (including a greater preference for those States with smaller resident-to-medical-student ratios). In determining the number of medical students in a State for purposes of the preceding sentence, the Secretary shall include planned students at medical schools which have provisional accreditation by the Liaison Committee on Medical Education or the American Osteopathic Association.

“(iv) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

“(E) LIMITATION.—

“(i) IN GENERAL.—Except as provided in clause (ii), in no case may a hospital (other than a hospital described in subparagraph (B)(ii)(I), subject to the limitation under subparagraph (B)(ii)(III)) apply for more than 50 full-time equivalent

1 additional residency positions under this
2 paragraph.

3 “(ii) INCREASE IN NUMBER OF ADDI-
4 TIONAL POSITIONS AVAILABLE FOR DIS-
5 TRIBUTION.—The Secretary shall increase
6 the number of full-time equivalent addi-
7 tional residency positions a hospital may
8 apply for under this paragraph if the Sec-
9 retary determines that the number of addi-
10 tional residency positions available for dis-
11 tribution under subparagraph (A)(ii) ex-
12 ceeds the number of such applications ap-
13 proved.

14 “(F) APPLICATION OF PER RESIDENT
15 AMOUNTS FOR PRIMARY CARE AND NONPRI-
16 MARY CARE.—With respect to additional resi-
17 dency positions in a hospital attributable to the
18 increase provided under this paragraph, the ap-
19 proved FTE resident amounts are deemed to be
20 equal to the hospital per resident amounts for
21 primary care and nonprimary care computed
22 under paragraph (2)(D) for that hospital.

23 “(G) DISTRIBUTION.—The Secretary shall
24 distribute the increase to hospitals under this

1 paragraph not later than 2 years after the date
2 of enactment of this paragraph.”.

3 (b) IME.—

4 (1) IN GENERAL.—Section 1886(d)(5)(B)(v) of
5 the Social Security Act (42 U.S.C.
6 1395ww(d)(5)(B)(v)), in the second sentence, is
7 amended—

8 (A) by striking “subsection (h)(7)” and in-
9 serting “subsections (h)(7) and (h)(8)”; and

10 (B) by striking “it applies” and inserting
11 “they apply”.

12 (2) CONFORMING PROVISION.—Section
13 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
14 1395ww(d)(5)(B)) is amended by adding at the end
15 the following clause:

16 “(x) For discharges occurring on or after the
17 date of enactment of this clause, insofar as an addi-
18 tional payment amount under this subparagraph is
19 attributable to resident positions distributed to a
20 hospital under subsection (h)(8)(B), the indirect
21 teaching adjustment factor shall be computed in the
22 same manner as provided under clause (ii) with re-
23 spect to such resident positions.”.

1 **SEC. 2327. COUNTING RESIDENT TIME IN OUTPATIENT SET-**
 2 **TINGS.**

3 (a) D-GME.—Section 1886(h)(4)(E) of the Social
 4 Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

5 (1) by striking “under an approved medical
 6 residency training program”; and

7 (2) by striking “if the hospital incurs all, or
 8 substantially all, of the costs for the training pro-
 9 gram in that setting” and inserting “if the hospital
 10 continues to incur the costs of the stipends and
 11 fringe benefits of the resident during the time the
 12 resident spends in that setting”.

13 (b) IME.—Section 1886(d)(5)(B)(iv) of the Social
 14 Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amend-
 15 ed—

16 (1) by striking “under an approved medical
 17 residency training program”; and

18 (2) by striking “if the hospital incurs all, or
 19 substantially all, of the costs for the training pro-
 20 gram in that setting” and inserting “if the hospital
 21 continues to incur the costs of the stipends and
 22 fringe benefits of the intern or resident during the
 23 time the intern or resident spends in that setting”.

24 (c) EFFECTIVE DATES; APPLICATION.—

25 (1) IN GENERAL.—Effective for cost reporting
 26 periods beginning on or after July 1, 2009, the Sec-

1 retary of Health and Human Services shall imple-
 2 ment the amendments made by this section in a
 3 manner so as to apply to cost reporting periods be-
 4 ginning on or after July 1, 2009.

5 (2) APPLICATION.—The amendments made by
 6 this section shall not be applied in a manner that re-
 7 quires reopening of any settled hospital cost reports
 8 as to which there is not a jurisdictionally proper ap-
 9 peal pending as of the date of the enactment of this
 10 Act on the issue of payment for indirect costs of
 11 medical education under section 1886(d)(5)(B) of
 12 the Social Security Act (42 U.S.C.
 13 1395ww(d)(5)(B)) or for direct graduate medical
 14 education costs under section 1886(h) of such Act
 15 (42 U.S.C. 1395ww(h)).

16 **SEC. 2328. RULES FOR COUNTING RESIDENT TIME FOR DI-**
 17 **DACTIC AND SCHOLARLY ACTIVITIES AND**
 18 **OTHER ACTIVITIES.**

19 (a) GME.—Section 1886(h) of the Social Security
 20 Act (42 U.S.C. 1395ww(h)), as amended by section
 21 2327(a), is amended—

22 (1) in paragraph (4)(E)—

23 (A) by designating the first sentence as a
 24 clause (i) with the heading “IN GENERAL” and
 25 appropriate indentation and by striking “Such

rules” and inserting “Subject to clause (ii),
such rules”; and

(B) by adding at the end the following new
clause:

“(ii) TREATMENT OF CERTAIN NON-
HOSPITAL AND DIDACTIC ACTIVITIES.—

Such rules shall provide that all time spent
by an intern or resident in an approved
medical residency training program in a
nonhospital setting that is primarily en-
gaged in furnishing patient care (as de-
fined in paragraph (5)(K)) in non-patient
care activities, such as didactic conferences
and seminars, but not including research
not associated with the treatment or diag-
nosis of a particular patient, as such time
and activities are defined by the Secretary,
shall be counted toward the determination
of full-time equivalency.”;

(2) in paragraph (4), by adding at the end the
following new subparagraph:

“(I) In determining the hospital’s number
of full-time equivalent residents for purposes of
this subsection, all the time that is spent by an
intern or resident in an approved medical resi-

1 dency training program on vacation, sick leave,
2 or other approved leave, as such time is defined
3 by the Secretary, and that does not prolong the
4 total time the resident is participating in the
5 approved program beyond the normal duration
6 of the program shall be counted toward the de-
7 termination of full-time equivalency.”; and

8 (3) in paragraph (5), by adding at the end the
9 following new subparagraph:

10 “(M) NONHOSPITAL SETTING THAT IS PRI-
11 MARILY ENGAGED IN FURNISHING PATIENT
12 CARE.—The term ‘nonhospital setting that is
13 primarily engaged in furnishing patient care’
14 means a nonhospital setting in which the pri-
15 mary activity is the care and treatment of pa-
16 tients, as defined by the Secretary.”.

17 (b) IME DETERMINATIONS.—Section 1886(d)(5)(B)
18 of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by
19 section 2326(b), is amended by adding at the end the fol-
20 lowing new clause:

21 “(xi)(I) The provisions of subparagraph (I) of
22 subsection (h)(4) shall apply under this subpara-
23 graph in the same manner as they apply under such
24 subsection.

1 “(II) In determining the hospital’s number of
2 full-time equivalent residents for purposes of this
3 subparagraph, all the time spent by an intern or
4 resident in an approved medical residency training
5 program in non-patient care activities, such as di-
6 dactic conferences and seminars, as such time and
7 activities are defined by the Secretary, that occurs in
8 the hospital shall be counted toward the determina-
9 tion of full-time equivalency if the hospital—

10 “(aa) is recognized as a subsection (d) hos-
11 pital;

12 “(bb) is recognized as a subsection (d)
13 Puerto Rico hospital;

14 “(cc) is reimbursed under a reimbursement
15 system authorized under section 1814(b)(3); or

16 “(dd) is a provider-based hospital out-
17 patient department.

18 “(III) In determining the hospital’s number of
19 full-time equivalent residents for purposes of this
20 subparagraph, all the time spent by an intern or
21 resident in an approved medical residency training
22 program in research activities that are not associ-
23 ated with the treatment or diagnosis of a particular
24 patient, as such time and activities are defined by

1 the Secretary, shall not be counted toward the deter-
 2 mination of full-time equivalency.”.

3 (c) EFFECTIVE DATES; APPLICATION.—

4 (1) IN GENERAL.—Except as otherwise pro-
 5 vided, the Secretary of Health and Human Services
 6 shall implement the amendments made by this sec-
 7 tion in a manner so as to apply to cost reporting pe-
 8 riods beginning on or after January 1, 1983.

9 (2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of
 10 the Social Security Act, as added by subsection
 11 (a)(1)(B), shall apply to cost reporting periods be-
 12 ginning on or after July 1, 2009.

13 (3) IME.—Section 1886(d)(5)(B)(xi)(III) of
 14 the Social Security Act, as added by subsection (b),
 15 shall apply to cost reporting periods beginning on or
 16 after October 1, 2001. Such section, as so added,
 17 shall not give rise to any inference on how the law
 18 in effect prior to such date should be interpreted.

19 (4) APPLICATION.—The amendments made by
 20 this section shall not be applied in a manner that re-
 21 quires reopening of any settled hospital cost reports
 22 as to which there is not a jurisdictionally proper ap-
 23 peal pending as of the date of the enactment of this
 24 Act on the issue of payment for indirect costs of
 25 medical education under section 1886(d)(5)(B) of

1 the Social Security Act or for direct graduate med-
 2 ical education costs under section 1886(h) of such
 3 Act.

4 **SEC. 2329. PRESERVATION OF RESIDENT CAP POSITIONS**
 5 **FROM CLOSED AND ACQUIRED HOSPITALS.**

6 (a) GME.—Section 1886(h)(4)(H) of the Social Se-
 7 curity Act (42 U.S.C. 1395ww(h)(4)(H)) is amended by
 8 adding at the end the following new clauses:

9 “(vi) REDISTRIBUTION OF RESIDENCY
 10 SLOTS AFTER A HOSPITAL CLOSES.—

11 “(I) IN GENERAL.—Subject to
 12 the succeeding provisions of this
 13 clause, the Secretary shall, by regula-
 14 tion, establish a process under which,
 15 in the case where a hospital with an
 16 approved medical residency program
 17 closes on or after the date of enact-
 18 ment of the Balanced Budget Act of
 19 1997, the Secretary shall increase the
 20 otherwise applicable resident limit
 21 under this paragraph for other hos-
 22 pitals in accordance with this clause.

23 “(II) PRIORITY FOR HOSPITALS
 24 IN CERTAIN AREAS.—Subject to the
 25 succeeding provisions of this clause, in

1 determining for which hospitals the
2 increase in the otherwise applicable
3 resident limit is provided under such
4 process, the Secretary shall distribute
5 the increase to hospitals located in the
6 following priority order (with pref-
7 erence given within each category to
8 hospitals that are members of the
9 same affiliated group (as defined by
10 the Secretary under clause (ii)) as the
11 closed hospital):

12 “(aa) First, to hospitals lo-
13 cated in the same core-based sta-
14 tistical area as, or a core-based
15 statistical area contiguous to, the
16 hospital that closed.

17 “(bb) Second, to hospitals
18 located in the same State as the
19 hospital that closed.

20 “(cc) Third, to hospitals lo-
21 cated in the same region of the
22 country as the hospital that
23 closed.

24 “(dd) Fourth, to all other
25 hospitals.

1 “(III) REQUIREMENT HOSPITAL
2 LIKELY TO FILL POSITION WITHIN
3 CERTAIN TIME PERIOD.—The Sec-
4 retary may only increase the otherwise
5 applicable resident limit of a hospital
6 under such process if the Secretary
7 determines the hospital has dem-
8 onstrated a likelihood of filling the po-
9 sitions made available under this
10 clause within 3 years.

11 “(IV) LIMITATION.—The aggre-
12 gate number of increases in the other-
13 wise applicable resident limits for hos-
14 pitals under this clause shall be equal
15 to the number of resident positions in
16 the approved medical residency pro-
17 grams that closed on or after the date
18 described in subclause (I).

19 “(vii) SPECIAL RULE FOR ACQUIRED
20 HOSPITALS.—

21 “(I) IN GENERAL.—In the case
22 of a hospital that is acquired (through
23 any mechanism) by another entity
24 with the approval of a bankruptcy
25 court, during a period determined by

1 the Secretary (but not less than 3
2 years), the applicable resident limit of
3 the acquired hospital shall, except as
4 provided in subclause (II), be the ap-
5 plicable resident limit of the hospital
6 that was acquired (as of the date im-
7 mediately before the acquisition),
8 without regard to whether the acquir-
9 ing entity accepts assignment of the
10 Medicare provider agreement of the
11 hospital that was acquired, so long as
12 the acquiring entity continues to oper-
13 ate the hospital that was acquired and
14 to furnish services, medical residency
15 programs, and volume of patients
16 similar to the services, medical resi-
17 dency programs, and volume of pa-
18 tients of the hospital that was ac-
19 quired (as determined by the Sec-
20 retary) during such period.

21 “(II) LIMITATION.—Subclause
22 (I) shall only apply in the case where
23 an acquiring entity waives the right as
24 a new provider under the program
25 under this title to have the otherwise

1 applicable resident limit of the ac-
2 quired hospital re-established or in-
3 creased.”.

4 (b) IME.—Section 1886(d)(5)(B)(v) of the Social Se-
5 curity Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second
6 sentence, as amended by section 2326(b), is amended by
7 striking “subsections (h)(7) and (h)(8)” and inserting
8 “subsections (h)(4)(H)(vi), (h)(4)(H)(vii), (h)(7), and
9 (h)(8)”.

10 (c) APPLICATION.—The amendments made by this
11 section shall not be applied in a manner that requires re-
12 opening of any settled hospital cost reports as to which
13 there is not a jurisdictionally proper appeal pending as
14 of the date of the enactment of this Act on the issue of
15 payment for indirect costs of medical education under sec-
16 tion 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
17 1395ww(d)(5)(B)) or for direct graduate medical edu-
18 cation costs under section 1886(h) of such Act (42 U.S.C.
19 1395ww(h)).

20 (d) NO AFFECT ON TEMPORARY FTE CAP ADJUST-
21 MENTS.—The amendments made by this section shall not
22 affect any temporary adjustment to a hospital’s FTE cap
23 under section 413.79(h) of title 42, Code of Federal Regu-
24 lations (as in effect on the date of enactment of this Act).

1 **SEC. 2330. QUALITY IMPROVEMENT ORGANIZATION ASSIST-**
 2 **ANCE FOR PHYSICIAN PRACTICES SEEKING**
 3 **TO BE PATIENT-CENTERED MEDICAL HOME**
 4 **PRACTICES.**

5 Not later than 90 days after the date of enactment
 6 of this Act, the Secretary of Health and Human Services
 7 shall revise the 9th Statement of Work under the Quality
 8 Improvement Program under part B of title XI of the So-
 9 cial Security Act to include a requirement that, in order
 10 to be an eligible Quality Improvement Organization (in
 11 this section referred to as a “QIO”) for the 9th Statement
 12 of Work contract cycle, a QIO shall provide assistance,
 13 including technical assistance, to physicians under the
 14 Medicare program under title XVIII of the Social Security
 15 Act that seek to acquire the elements necessary to be rec-
 16 ognized as a patient-centered medical home practice under
 17 the National Committee for Quality Assurance’s Physician
 18 Practice Connections—PCMH module (or any successor
 19 module issued by such Committee).

20 **Subtitle D—Studies**

21 **SEC. 2401. STUDY CONCERNING THE DESIGNATION OF PRI-**
 22 **MARY CARE AS A SHORTAGE PROFESSION.**

23 (a) IN GENERAL.—Not later than June 30, 2010, the
 24 Secretary of Labor shall conduct a study and submit to
 25 the Committee on Education and Labor of the House of

1 Representatives and the Committee on Health, Education,
2 Labor, and Pensions a report that contains—

3 (1) a description of the criteria for the designa-
4 tion of primary care physicians as professions in
5 shortage as defined by the Secretary under section
6 212(a)(5)(A) of the Immigration and Nationality
7 Act;

8 (2) the findings of the Secretary on whether
9 primary care physician professions will, on the date
10 on which the report is submitted, or within the 5-
11 year period beginning on such date, satisfy the cri-
12 teria referred to in paragraph (1); and

13 (3) if the Secretary finds that such professions
14 will not satisfy such criteria, recommendations for
15 modifications to such criteria to enable primary care
16 physicians to be so designated as a profession in
17 shortage.

18 (b) REQUIREMENTS.—In conducting the study under
19 subsection (a), the Secretary of Labor shall consider work-
20 force data from the Health Resources and Services Admin-
21 istration, the Council on Graduate Medical Education, the
22 Association of American Medical Colleges, and input from
23 physician membership organizations that represent pri-
24 mary care physicians.

1 **SEC. 2402. STUDY CONCERNING THE EDUCATION DEBT OF**
 2 **MEDICAL SCHOOL GRADUATES.**

3 (a) STUDY.—The Comptroller General of the United
 4 States shall conduct a study to evaluate the higher edu-
 5 cation-related indebtedness of medical school graduates in
 6 the United States at the time of graduation from medical
 7 school, and the impact of such indebtedness on specialty
 8 choice, including the impact on the field of primary care.

9 (b) REPORT.—

10 (1) SUBMISSION AND DISSEMINATION OF RE-
 11 PORT.—Not later than 1 year after the date of en-
 12 actment of this Act, the Comptroller General shall
 13 submit a report on the study required by subsection
 14 (a) to the Committee on Health, Education, Labor,
 15 and Pensions of the Senate and the Committee on
 16 Education and Labor of the House of Representa-
 17 tives, and shall make such report widely available to
 18 the public.

19 (2) ADDITIONAL REPORTS.—The Comptroller
 20 General may periodically prepare and release as nec-
 21 essary additional reports on the topic described in
 22 subsection (a).

23 **SEC. 2403. STUDY ON MINORITY REPRESENTATION IN PRI-**
 24 **MARY CARE.**

25 (a) STUDY.—The Secretary of Health and Human
 26 Services, acting through the Administrator of the Health

1 Resources and Services Administration, shall conduct a
 2 study of minority representation in training, and in prac-
 3 tice, in primary care specialties.

4 (b) REPORT.—Not later than 1 year after the date
 5 of enactment of this Act, the Secretary of Health and
 6 Human Services, acting through the Administrator of the
 7 Health Resources and Services Administration, shall sub-
 8 mit to the appropriate committees of Congress a report
 9 concerning the study conducted under subsection (a), in-
 10 cluding recommendations for achieving a primary care
 11 workforce that is more representative of the population of
 12 the United States.

13 **TITLE III—MEDICARE PAYMENT** 14 **PROVISIONS**

15 **SEC. 3001. SHORT TITLE.**

16 This title may be cited as the “Medicare Payment
 17 Improvement Act of 2009”.

18 **SEC. 3002. FINDINGS.**

19 Congress makes the following findings:

20 (1) The health care delivery system must be re-
 21 aligned to provide better clinical outcomes, safety,
 22 and patient satisfaction at lower cost. This should be
 23 a common goal for all health care professionals, hos-
 24 pitals, and other groups. Today’s reimbursement
 25 system pays the most to those who perform the most

1 services, and therefore can provide disincentives to
 2 efficient and high-quality providers.

3 (2) The regional inequities in Medicare reim-
 4 bursement penalize areas that have cost-effective
 5 health care delivery systems and reward those States
 6 that have high utilization rates and provide ineffi-
 7 cient care.

8 (3) According to the Dartmouth Health Atlas,
 9 over the past 10 years, a number of studies have ex-
 10 plored the relationship between higher spending and
 11 the quality and outcomes of care. The findings are
 12 remarkably consistent, concluding that higher spend-
 13 ing does not result in better quality of care.

14 (4) New payment models should be developed to
 15 move away from paying for quantity and instead
 16 paying for improving health and truly rewarding ef-
 17 fective and efficient care.

18 **SEC. 3003. VALUE INDEX UNDER THE MEDICARE PHYSI-**
 19 **CIAN FEE SCHEDULE.**

20 (a) IN GENERAL.—Section 1848(e)(5) of the Social
 21 Security Act (42 U.S.C. 1395w–4(e)) is amended by add-
 22 ing at the end the following new paragraph:

23 “(6) VALUE INDEX.—

24 “(A) IN GENERAL.—The Secretary shall
 25 determine a value index for each fee schedule

1 area. The value index shall be the ratio of the
 2 quality component under subparagraph (B) to
 3 the cost component under subparagraph (C) for
 4 that fee schedule area.

5 “(B) QUALITY COMPONENT.—

6 “(i) IN GENERAL.—The quality com-
 7 ponent shall be based on a composite score
 8 that reflects quality measures available on
 9 a State or fee schedule area basis. The
 10 measures shall reflect health outcomes and
 11 health status for the Medicare population,
 12 patient safety, and patient satisfaction.
 13 The Secretary shall use the best data
 14 available, after consultation with the Agen-
 15 cy for Healthcare Research and Quality
 16 and with private entities that compile qual-
 17 ity data.

18 “(ii) ADVISORY GROUP.—

19 “(I) IN GENERAL.—Not later
 20 than 60 days after the date of enact-
 21 ment of the Medicare Payment Im-
 22 provement Act of 2009, the Secretary
 23 shall establish a group of experts and
 24 stakeholders to make consensus rec-
 25 ommendations to the Secretary re-

1 garding development of the quality
2 component. The membership of the
3 advisory group shall at least reflect
4 providers, purchasers, health plans,
5 researchers, relevant Federal agencies,
6 and individuals with technical exper-
7 tise on health care quality.

8 “(II) DUTIES.—In the develop-
9 ment of recommendations with respect
10 to the quality component, the group
11 established under subclause (I) shall
12 consider at least the following areas:

13 “(aa) High cost procedures
14 as determined by data under this
15 title.

16 “(bb) Health outcomes and
17 functional status of patients.

18 “(cc) The continuity, man-
19 agement, and coordination of
20 health care and care transitions,
21 including episodes of care, for pa-
22 tients across the continuum of
23 providers, health care settings,
24 and health plans.

1 “(dd) Patient, caregiver, and
2 authorized representative experi-
3 ence, quality and relevance of in-
4 formation provided to patients,
5 caregivers, and authorized rep-
6 resentatives, and use of informa-
7 tion by patients, caregivers, and
8 authorized representatives to in-
9 form decision making.

10 “(ee) The safety, effective-
11 ness, and timeliness of care.

12 “(ff) The appropriate use of
13 health care resources and serv-
14 ices.

15 “(gg) Other items deter-
16 mined appropriate by the Sec-
17 retary.

18 “(iii) REQUIREMENT.—In establishing
19 the quality component under this subpara-
20 graph, the Secretary shall—

21 “(I) take into account the rec-
22 ommendations of the group estab-
23 lished under clause (ii)(I); and

24 “(II) provide for an open and
25 transparent process for the activities

1 conducted pursuant to the convening
2 of such group with respect to the de-
3 velopment of the quality component.

4 “(iv) ESTABLISHMENT.—The quality
5 component for each fee schedule area shall
6 be the ratio of the quality score for such
7 area to the national average quality score.

8 “(v) QUALITY BASELINE.—If the
9 quality component for a fee schedule area
10 does not rank in the top 25th percentile as
11 compared to the national average (as de-
12 termined by the Secretary) and the amount
13 of reimbursement for services under this
14 section is greater than the amount of reim-
15 bursement for such services that would
16 have applied under this section if the
17 amendments made by section 2 of the
18 Medicare Payment Improvement Act of
19 2009 had not been enacted, this section
20 shall be applied as if such amendments
21 had not been enacted.

22 “(vi) APPLICATION.—In the case of a
23 fee schedule area that is less than an en-
24 tire State, if available quality data is not
25 sufficient to measure quality at the sub-

1 State level, the quality component for a
 2 sub-State fee schedule area shall be the
 3 quality component for the entire State.

4 “(C) COST COMPONENT.—

5 “(i) IN GENERAL.—The cost compo-
 6 nent shall be total annual per beneficiary
 7 Medicare expenditures under part A and
 8 this part for the fee schedule area. The
 9 Secretary may use total per beneficiary ex-
 10 penditures under such parts in the last two
 11 years of life as an alternative measure if
 12 the Secretary determines that such meas-
 13 ure better takes into account severity dif-
 14 ferences among fee schedule areas.

15 “(ii) ESTABLISHMENT.—The cost
 16 component for a fee schedule area shall be
 17 the ratio of the cost per beneficiary for
 18 such area to the national average cost per
 19 beneficiary.”.

20 (b) CONFORMING AMENDMENTS.—Section 1848 of
 21 the Social Security Act (42 U.S.C. 1395w-4) is amend-
 22 ed—

23 (1) in subsection (b)(1)(C), by striking “geo-
 24 graphic” and inserting “geographic and value”; and

25 (2) in subsection (e)—

1 (A) in paragraph (1)—

2 (i) in the heading, by inserting “AND
3 VALUE” after “GEOGRAPHIC”;

4 (ii) in subparagraph (A), by striking
5 clause (iii) and inserting the following new
6 clause:

7 “(iii) a value index (as defined in
8 paragraph (6)) applicable to physician
9 work.”;

10 (iii) in subparagraph (C), by inserting
11 “and value” after “geographic” in the first
12 sentence;

13 (iv) in subparagraph (D), by striking
14 “physician work effort” and inserting
15 “value”;

16 (v) by striking subparagraph (E); and

17 (vi) by striking subparagraph (G);

18 (B) by striking paragraph (2) and insert-
19 ing the following new paragraph:

20 “(2) COMPUTATION OF GEOGRAPHIC AND
21 VALUE ADJUSTMENT FACTOR.—For purposes of sub-
22 section (b)(1)(C), for all physicians’ services for each
23 fee schedule area the Secretary shall establish a geo-
24 graphic and value adjustment factor equal to the
25 sum of the geographic cost-of-practice adjustment

1 factor (specified in paragraph (3)), the geographic
 2 malpractice adjustment factor (specified in para-
 3 graph (4)), and the value adjustment factor (speci-
 4 fied in paragraph (5)) for the service and the area.”;
 5 and

6 (C) by striking paragraph (5) and insert-
 7 ing the following new paragraph:

8 “(5) PHYSICIAN WORK VALUE ADJUSTMENT
 9 FACTOR.—For purposes of paragraph (2), the ‘phy-
 10 sician work value adjustment factor’ for a service for
 11 a fee schedule area, is the product of—

12 “(A) the proportion of the total relative
 13 value for the service that reflects the relative
 14 value units for the work component; and

15 “(B) the value index score for the area,
 16 based on the value index established under
 17 paragraph (6).”.

18 (c) AVAILABILITY OF QUALITY COMPONENT PRIOR
 19 TO IMPLEMENTATION.—The Secretary of Health and
 20 Human Services shall make the quality component de-
 21 scribed in section 1848(c)(6)(B) of the Social Security
 22 Act, as added by subsection (a), for each fee schedule area
 23 available to the public by not later than July 1, 2011.

24 (d) EFFECTIVE DATE.—Subject to subsection (e),
 25 the amendments made by this section shall apply to the

1 Medicare physician fee schedule for 2012 and each subse-
2 quent year.

3 (e) TRANSITION.—Notwithstanding the amendments
4 made by the preceding provisions of this section, the Sec-
5 retary of Health and Human Services shall provide for an
6 appropriate transition to the amendments made by this
7 section. Under such transition, in the case of payments
8 under such fee schedule for services furnished during—

9 (1) 2012, 25 percent of such payments shall be
10 based on the amount of payment that would have
11 applied to the services if such amendments had not
12 been enacted and 75 percent of such payment shall
13 be based on the amount of payment that would have
14 applied to the services if such amendments had been
15 fully implemented;

16 (2) 2013, 50 percent of such payment shall be
17 based on the amount of payment that would have
18 applied to the services if such amendments had not
19 been enacted and 50 percent of such payment shall
20 be based on the amount of payment that would have
21 applied to the services if such amendments had been
22 fully implemented; and

23 (3) 2014 and subsequent years, 100 percent of
24 such payment shall be based on the amount of pay-
25 ment that is applicable under such amendments.

TITLE IV—LONG-TERM SERVICES PROVISIONS

SEC. 4001. SHORT TITLE.

This title may be cited as the “Home and Community
Balanced Incentives Act of 2009”.

Subtitle A—Balancing Incentives

SEC. 4101. ENHANCED FMAP FOR EXPANDING THE PROVI- SION OF NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.

(a) ENHANCED FMAP TO ENCOURAGE EXPAN-
SION.—Section 1905 of the Social Security Act (42 U.S.C.
1396d) is amended—

(1) in the first sentence of subsection (b)—

(A) by striking “, and (4)” and inserting
“, (4)”;

(B) by inserting before the period the fol-
lowing: “, and (5) in the case of a balancing in-
centive payment State, as defined in subsection
(y)(1), that meets the conditions described in
subsection (y)(2), the Federal medical assist-
ance percentage shall be increased by the appli-
cable number of percentage points determined
under subsection (y)(3) for the State with re-
spect to medical assistance described in sub-
section (y)(4)”;

1 (2) by adding at the end the following new sub-
2 section:

3 “(y) STATE BALANCING INCENTIVE PAYMENTS PRO-
4 GRAM.—For purposes of clause (5) of the first sentence
5 of subsection (b):

6 “(1) BALANCING INCENTIVE PAYMENT
7 STATE.—A balancing incentive payment State is a
8 State—

9 “(A) in which less than 50 percent of the
10 total expenditures for medical assistance for fis-
11 cal year 2009 for long-term services and sup-
12 ports (as defined by the Secretary, subject to
13 paragraph (5)) are for non-institutionally-based
14 long-term services and supports described in
15 paragraph (5)(B);

16 “(B) that submits an application and
17 meets the conditions described in paragraph
18 (2); and

19 “(C) that is selected by the Secretary to
20 participate in the State balancing incentive pay-
21 ment program established under this sub-
22 section.

23 “(2) CONDITIONS.—The conditions described in
24 this paragraph are the following:

1 “(A) APPLICATION.—The State submits an
2 application to the Secretary that includes the
3 following:

4 “(i) A description of the availability of
5 non-institutionally-based long-term services
6 and supports described in paragraph
7 (5)(B) available (for fiscal years beginning
8 with fiscal year 2009).

9 “(ii) A description of eligibility re-
10 quirements for receipt of such services.

11 “(iii) A projection of the number of
12 additional individuals that the State ex-
13 pects to provide with such services to dur-
14 ing the 5-fiscal-year period that begins
15 with fiscal year 2011.

16 “(iv) An assurance of the State’s com-
17 mitment to a consumer-directed long-term
18 services and supports system that values
19 quality of life in addition to quality of care
20 and in which beneficiaries are empowered
21 to choose providers and direct their own
22 care as much as possible.

23 “(v) A proposed budget that details
24 the State’s plan to expand and diversify
25 medical assistance for non-institutionally-

1 based long-term services and supports de-
 2 scribed in paragraph (5)(B) during such 5-
 3 fiscal-year period, and that includes—

4 “(I) a description of the new or
 5 expanded offerings of such services
 6 that the State will provide; and

7 “(II) the projected costs of the
 8 services identified in subclause (I).

9 “(vi) A description of how the State
 10 intends to achieve the target spending per-
 11 centage applicable to the State under sub-
 12 paragraph (B).

13 “(vii) An assurance that the State will
 14 not use Federal funds, revenues described
 15 in section 1903(w)(1), or revenues ob-
 16 tained through the imposition of bene-
 17 ficiary cost-sharing for medical assistance
 18 for non-institutionally-based long-term
 19 services and supports described in para-
 20 graph (5)(B) for the non-Federal share of
 21 expenditures for medical assistance de-
 22 scribed in paragraph (4).

23 “(B) TARGET SPENDING PERCENTAGES.—

24 “(i) In the case of a balancing incen-
 25 tive payment State in which less than 25

1 percent of the total expenditures for home
2 and community-based services under the
3 State plan and the various waiver authori-
4 ties for fiscal year 2009 are for such serv-
5 ices, the target spending percentage for the
6 State to achieve by not later than October
7 1, 2015, is that 25 percent of the total ex-
8 penditures for home and community-based
9 services under the State plan and the var-
10 ious waiver authorities are for such serv-
11 ices.

12 “(ii) In the case of any other bal-
13 ancing incentive payment State, the target
14 spending percentage for the State to
15 achieve by not later than October 1, 2015,
16 is that 50 percent of the total expenditures
17 for home and community-based services
18 under the State plan and the various waiv-
19 er authorities are for such services.

20 “(C) MAINTENANCE OF ELIGIBILITY RE-
21 QUIREMENTS.—The State does not apply eligi-
22 bility standards, methodologies, or procedures
23 for determining eligibility for medical assistance
24 for non-institutionally-based long-term services
25 and supports described in paragraph (5)(B))

1 that are more restrictive than the eligibility
2 standards, methodologies, or procedures in ef-
3 fect for such purposes on December 31, 2010.

4 “(D) USE OF ADDITIONAL FUNDS.—The
5 State agrees to use the additional Federal funds
6 paid to the State as a result of this subsection
7 only for purposes of providing new or expanded
8 offerings of non-institutionally-based long-term
9 services and supports described in paragraph
10 (5)(B) (including expansion through offering
11 such services to increased numbers of bene-
12 ficiaries of medical assistance under this title).

13 “(E) STRUCTURAL CHANGES.—The State
14 agrees to make, not later than the end of the
15 6-month period that begins on the date the
16 State submits and application under this para-
17 graph, such changes to the administration of
18 the State plan (and, if applicable, to waivers ap-
19 proved for the State that involve the provision
20 of long-term care services and supports) as the
21 Secretary determines, by regulation or other-
22 wise, are essential to achieving an improved bal-
23 ance between the provision of non-institution-
24 ally-based long-term services and supports de-
25 scribed in paragraph (5)(B) and other long-

1 term services and supports, and which shall in-
2 clude the following:

3 “(i) ‘No WRONG DOOR’—SINGLE
4 ENTRY POINT SYSTEM.—Development of a
5 statewide system to enable consumers to
6 access all long-term services and supports
7 through an agency, organization, coordi-
8 nated network, or portal, in accordance
9 with such standards as the State shall es-
10 tablish and that—

11 “(I) shall require such agency,
12 organization, network, or portal to
13 provide—

14 “(aa) consumers with infor-
15 mation regarding the availability
16 of such services, how to apply for
17 such services, and other referral
18 services; and

19 “(bb) information regarding,
20 and make recommendations for,
21 providers of such services; and

22 “(II) may, at State option, per-
23 mit such agency, organization, net-
24 work, or portal to—

1 “(aa) determine financial
2 and functional eligibility for such
3 services and supports; and

4 “(bb) provide or refer eligi-
5 ble individuals to services and
6 supports otherwise available in
7 the community (under programs
8 other than the State program
9 under this title), such as housing,
10 job training, and transportation.

11 “(ii) PRESUMPTIVE ELIGIBILITY.—At
12 the option of the State, provision of a 60-
13 day period of presumptive eligibility for
14 medical assistance for non-institutionally-
15 based long-term services and supports de-
16 scribed in paragraph (5)(B) for any indi-
17 vidual whom the State has reason to be-
18 lieve will qualify for such medical assist-
19 ance (provided that any expenditures for
20 such medical assistance during such period
21 are disregarded for purposes of deter-
22 mining the rate of erroneous excess pay-
23 ments for medical assistance under section
24 1903(u)(1)(D)).

1 “(iii) CASE MANAGEMENT.—Develop-
2 ment, in accordance with guidance from
3 the Secretary, of conflict-free case manage-
4 ment services to—

5 “(I) address transitioning from
6 receipt of institutionally-based long-
7 term services and supports described
8 in paragraph (5)(A) to receipt of non-
9 institutionally-based long-term serv-
10 ices and supports described in para-
11 graph (5)(B); and

12 “(II) in conjunction with the ben-
13 eficiary, assess the beneficiary’s needs
14 and , if appropriate, the needs of fam-
15 ily caregivers for the beneficiary, and
16 develop a service plan, arrange for
17 services and supports, support the
18 beneficiary (and, if appropriate, the
19 caregivers) in directing the provision
20 of services and supports, for the bene-
21 ficiary, and conduct ongoing moni-
22 toring to assure that services and sup-
23 ports are delivered to meet the bene-
24 ficiary’s needs and achieve intended
25 outcomes.

1 “(iv) CORE STANDARDIZED ASSESS-
2 MENT INSTRUMENTS.—Development of
3 core standardized assessment instruments
4 for determining eligibility for non-institu-
5 tionally-based long-term services and sup-
6 ports described in paragraph (5)(B), which
7 shall be used in a uniform manner
8 throughout the State, to—

9 “(I) assess a beneficiary’s eligi-
10 bility and functional level in terms of
11 relevant areas that may include med-
12 ical, cognitive, and behavioral status,
13 as well as daily living skills, and voca-
14 tional and communication skills;

15 “(II) based on the assessment
16 conducted under subclause (I), deter-
17 mine a beneficiary’s needs for train-
18 ing, support services, medical care,
19 transportation, and other services,
20 and develop an individual service plan
21 to address such needs;

22 “(III) conduct ongoing moni-
23 toring based on the service plan; and

1 “(IV) require reporting of collect
2 data for purposes of comparison
3 among different service models.

4 “(F) DATA COLLECTION.—Collecting from
5 providers of services and through such other
6 means as the State determines appropriate the
7 following data:

8 “(i) SERVICES DATA.—Services data
9 from providers of non-institutionally-based
10 long-term services and supports described
11 in paragraph (5)(B) on a per-beneficiary
12 basis and in accordance with such stand-
13 ardized coding procedures as the State
14 shall establish in consultation with the Sec-
15 retary.

16 “(ii) QUALITY DATA.—Quality data
17 on a selected set of core quality measures
18 agreed upon by the Secretary and the
19 State that are linked to population-specific
20 outcomes measures and accessible to pro-
21 viders.

22 “(iii) OUTCOMES MEASURES.—Out-
23 comes measures data on a selected set of
24 core population-specific outcomes measures
25 agreed upon by the Secretary and the

1 State that are accessible to providers and
2 include—

3 “(I) measures of beneficiary and
4 family caregiver experience with pro-
5 viders;

6 “(II) measures of beneficiary and
7 family caregiver satisfaction with serv-
8 ices; and

9 “(III) measures for achieving de-
10 sired outcomes appropriate to a spe-
11 cific beneficiary, including employ-
12 ment, participation in community life,
13 health stability, and prevention of loss
14 in function.

15 “(3) APPLICABLE NUMBER OF PERCENTAGE
16 POINTS INCREASE IN FMAP.—The applicable number
17 of percentage points are—

18 “(A) in the case of a balancing incentive
19 payment State subject to the target spending
20 percentage described in paragraph (2)(B)(i), 5
21 percentage points; and

22 “(B) in the case of any other balancing in-
23 centive payment State, 2 percentage points.

24 “(4) ELIGIBLE MEDICAL ASSISTANCE EXPENDI-
25 TURES.—

1 “(A) IN GENERAL.—Subject to subpara-
 2 graph (B), medical assistance described in this
 3 paragraph is medical assistance for non-institu-
 4 tionally-based long-term services and supports
 5 described in paragraph (5)(B) that is provided
 6 during the period that begins on October 1,
 7 2011, and ends on September 30, 2015.

8 “(B) LIMITATION ON PAYMENTS.—In no
 9 case may the aggregate amount of payments
 10 made by the Secretary to balancing incentive
 11 payment States under this subsection during
 12 the period described in subparagraph (A), or to
 13 a State to which paragraph (6) of the first sen-
 14 tence of subsection (b) applies, exceed
 15 \$3,000,000,000.

16 “(5) LONG-TERM SERVICES AND SUPPORTS DE-
 17 FINED.—In this subsection, the term ‘long-term
 18 services and supports’ has the meaning given that
 19 term by Secretary and shall include the following:

20 “(A) INSTITUTIONALLY-BASED LONG-TERM
 21 SERVICES AND SUPPORTS.—Services provided
 22 in an institution, including the following:

23 “(i) Nursing facility services.

1 “(ii) Services in an intermediate care
 2 facility for the mentally retarded described
 3 in subsection (a)(15).

4 “(B) NON-INSTITUTIONALLY-BASED LONG-
 5 TERM SERVICES AND SUPPORTS.—Services not
 6 provided in an institution, including the fol-
 7 lowing:

8 “(i) Home and community-based serv-
 9 ices provided under subsection (c), (d), or
 10 (i), of section 1915 or under a waiver
 11 under section 1115.

12 “(ii) Home health care services.

13 “(iii) Personal care services.

14 “(iv) Services described in subsection
 15 (a)(26) (relating to PACE program serv-
 16 ices).

17 “(v) Self-directed personal assistance
 18 services described in section 1915(j)”.

19 (b) ENHANCED FMAP FOR CERTAIN STATES TO
 20 MAINTAIN THE PROVISION OF HOME AND COMMUNITY-
 21 BASED SERVICES.—The first sentence of section 1905(b)
 22 of such Act (42 U.S.C. 1396d(b)), as amended by sub-
 23 section (a), is amended—

24 (1) by striking “, and (5)” and inserting “,
 25 (5)”; and

1 (2) by inserting before the period the following:

2 “, and (6) in the case of a State in which at least
 3 50 percent of the total expenditures for medical as-
 4 sistance for fiscal year 2009 for long-term services
 5 and supports (as defined by the Secretary for pur-
 6 poses of subsection (y)) are for non-institutionally-
 7 based long-term services and supports described in
 8 subsection (y)(5)(B), and which satisfies the require-
 9 ments of subparagraphs (A) (other than clauses (iii),
 10 (v), and (vi)), (C), and (F) of subsection (y)(2), and
 11 has implemented the structural changes described in
 12 each clause of subparagraph (E) of that subsection,
 13 the Federal medical assistance percentage shall be
 14 increased by 1 percentage point with respect to med-
 15 ical assistance described in subparagraph (A) of sub-
 16 section (y)(4) (but subject to the limitation described
 17 in subparagraph (B) of that subsection)”.

18 (c) GRANTS TO SUPPORT STRUCTURAL CHANGES.—

19 (1) IN GENERAL.—The Secretary of Health and
 20 Human Services shall award grants to States for the
 21 following purposes:

22 (A) To support the development of com-
 23 mon national set of coding methodologies and
 24 databases related to the provision of non-insti-
 25 tutionally-based long-term services and supports

1 described in paragraph (5)(B) of section
2 1905(y) of the Social Security Act (as added by
3 subsection (a)).

4 (B) To make structural changes described
5 in paragraph (2)(E) of section 1905(y) to the
6 State Medicaid program.

7 (2) PRIORITY.—In awarding grants for the pur-
8 pose described in paragraph (1)(A), the Secretary of
9 Health and Human Services shall give priority to
10 States in which at least 50 percent of the total ex-
11 penditures for medical assistance under the State
12 Medicaid program for fiscal year 2009 for long-term
13 services and supports, as defined by the Secretary
14 for purposes of section 1905(y) of the Social Secu-
15 rity Act, are for non-institutionally-based long-term
16 services and supports described in paragraph (5)(B)
17 of such section.

18 (3) COLLABORATION.—States awarded a grant
19 for the purpose described in paragraph (1)(A) shall
20 collaborate with other States, the National Gov-
21 ernor's Association, the National Conference of
22 State Legislatures, the National Association of State
23 Medicaid Directors, the National Association of
24 State Directors of Developmental Disabilities, and
25 other appropriate organizations in developing speci-

1 fications for a common national set of coding meth-
2 odologies and databases.

3 (4) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated to carry out
5 this subsection, such sums as may be necessary for
6 each of fiscal years 2010 through 2012.

7 (d) AUTHORITY FOR INDIVIDUALIZED BUDGETS
8 UNDER WAIVERS TO PROVIDE HOME AND COMMUNITY-
9 BASED SERVICES.—In the case of any waiver to provide
10 home and community-based services under subsection (c)
11 or (d) of section 1915 of the Social Security Act (42
12 U.S.C. 1396n) or section 1115 of such Act (42 U.S.C.
13 1315), that is approved or renewed after the date of enact-
14 ment of this Act, the Secretary of Health and Human
15 Services shall permit a State to establish individualized
16 budgets that identify the dollar value of the services and
17 supports to be provided to an individual under the waiver.

18 (e) OVERSIGHT AND ASSESSMENT.—

19 (1) DEVELOPMENT OF STANDARDIZED REPORT-
20 ING REQUIREMENTS.—

21 (A) STANDARDIZATION OF DATA AND OUT-
22 COME MEASURES.—The Secretary of Health
23 and Human Services shall consult with States
24 and the National Governor's Association, the
25 National Conference of State Legislatures, the

1 National Association of State Medicaid Direc-
 2 tors, the National Association of State Direc-
 3 tors of Developmental Disabilities, and other
 4 appropriate organizations to develop specifica-
 5 tions for standardization of—

6 (i) reporting of assessment data for
 7 long-term services and supports (as defined
 8 by the Secretary for purposes of section
 9 1905(y)(5) of the Social Security Act) for
 10 each population served, including informa-
 11 tion standardized for purposes of certified
 12 EHR technology (as defined in section
 13 1903(t)(3)(A) of the Social Security Act
 14 (42 U.S.C. 1396b(t)(3)(A)) and under
 15 other electronic medical records initiatives;
 16 and

17 (ii) outcomes measures that track as-
 18 sessment processes for long-term services
 19 and supports (as so defined) for each such
 20 population that maintain and enhance indi-
 21 vidual function, independence, and sta-
 22 bility.

23 (2) ADMINISTRATION OF HOME AND COMMU-
 24 NITY SERVICES.—The Secretary of Health and
 25 Human Services shall promulgate regulations to en-

1 sure that all States develop service systems that are
2 designed to—

3 (A) allocate resources for services in a
4 manner that is responsive to the changing
5 needs and choices of beneficiaries receiving non-
6 institutionally-based long-term services and sup-
7 ports described in paragraph (5)(B) of section
8 1905(y) of the Social Security Act (as added by
9 subsection (a)) (including such services and
10 supports that are provided under programs
11 other the State Medicaid program), and that
12 provides strategies for beneficiaries receiving
13 such services to maximize their independence;

14 (B) provide the support and coordination
15 needed for a beneficiary in need of such services
16 (and their family caregivers or representative, if
17 applicable) to design an individualized, self-di-
18 rected, community-supported life; and

19 (C) improve coordination among all pro-
20 viders of such services under federally and
21 State-funded programs in order to—

22 (i) achieve a more consistent adminis-
23 tration of policies and procedures across
24 programs in relation to the provision of
25 such services; and

1 (ii) oversee and monitor all service
2 system functions to assure—

3 (I) coordination of, and effective-
4 ness of, eligibility determinations and
5 individual assessments; and

6 (II) development and service
7 monitoring of a complaint system, a
8 management system, a system to
9 qualify and monitor providers, and
10 systems for role-setting and individual
11 budget determinations.

12 (3) MONITORING.—The Secretary of Health
13 and Human Services shall assess on an ongoing
14 basis and based on measures specified by the Agency
15 for Healthcare Research and Quality, the safety and
16 quality of non-institutionally-based long-term serv-
17 ices and supports described in paragraph (5)(B) of
18 section 1905(y) of that Act provided to beneficiaries
19 of such services and supports and the outcomes with
20 regard to such beneficiaries' experiences with such
21 services. Such oversight shall include examination
22 of—

23 (A) the consistency, or lack thereof, of
24 such services in care plans as compared to
25 those services that were actually delivered; and

1 (B) the length of time between when a
2 beneficiary was assessed for such services, when
3 the care plan was completed, and when the ben-
4 eficiary started receiving such services.

5 (4) GAO STUDY AND REPORT.—The Comp-
6 troller General of the United States shall study the
7 longitudinal costs of Medicaid beneficiaries receiving
8 long-term services and supports (as defined by the
9 Secretary for purposes of section 1905(y)(5) of the
10 Social Security Act) over 5-year periods across var-
11 ious programs, including the non-institutionally-
12 based long-term services and supports described in
13 paragraph (5)(B) of such section, PACE program
14 services under section 1894 of the Social Security
15 Act (42 U.S.C. 1395eee, 1396u–4), and services pro-
16 vided under specialized MA plans for special needs
17 individuals under part C of title XVIII of the Social
18 Security Act.

1 **Subtitle B—Strengthening the**
 2 **Medicaid Home and Commu-**
 3 **nity-Based State Plan Amend-**
 4 **ment Option**

5 **SEC. 4201. REMOVAL OF BARRIERS TO PROVIDING HOME**
 6 **AND COMMUNITY-BASED SERVICES UNDER**
 7 **STATE PLAN AMENDMENT OPTION FOR INDIV-**
 8 **IDUALS IN NEED.**

9 (a) PARITY WITH INCOME ELIGIBILITY STANDARD
 10 FOR INSTITUTIONALIZED INDIVIDUALS.—Paragraph (1)
 11 of section 1915(i) of the Social Security Act (42 U.S.C.
 12 1396n(i)) is amended by striking “150 percent of the pov-
 13 erty line (as defined in section 2110(c)(5))” and inserting
 14 “300 percent of the supplemental security income benefit
 15 rate established by section 1611(b)(1)”.

16 (b) ADDITIONAL STATE OPTIONS.—Section 1915(i)
 17 of the Social Security Act (42 U.S.C. 1396n(i)) is amend-
 18 ed by adding at the end the following new paragraphs:

19 “(6) STATE OPTION TO PROVIDE HOME AND
 20 COMMUNITY-BASED SERVICES TO INDIVIDUALS ELI-
 21 GIBLE FOR SERVICES UNDER A WAIVER.—

22 “(A) IN GENERAL.—A State that provides
 23 home and community-based services in accord-
 24 ance with this subsection to individuals who
 25 satisfy the needs-based criteria for the receipt

1 of such services established under paragraph
2 (1)(A) may, in addition to continuing to provide
3 such services to such individuals, elect to pro-
4 vide home and community-based services in ac-
5 cordance with the requirements of this para-
6 graph to individuals who are eligible for home
7 and community-based services under a waiver
8 approved for the State under subsection (c),
9 (d), or (e) or under section 1115 to provide
10 such services, but only for those individuals
11 whose income does not exceed 300 percent of
12 the supplemental security income benefit rate
13 established by section 1611(b)(1).

14 “(B) APPLICATION OF SAME REQUIRE-
15 MENTS FOR INDIVIDUALS SATISFYING NEEDS-
16 BASED CRITERIA.—Subject to subparagraph
17 (C), a State shall provide home and community-
18 based services to individuals under this para-
19 graph in the same manner and subject to the
20 same requirements as apply under the other
21 paragraphs of this subsection to the provision
22 of home and community-based services to indi-
23 viduals who satisfy the needs-based criteria es-
24 tablished under paragraph (1)(A).

1 “(C) AUTHORITY TO OFFER DIFFERENT
 2 TYPE, AMOUNT, DURATION, OR SCOPE OF HOME
 3 AND COMMUNITY-BASED SERVICES.—A State
 4 may offer home and community-based services
 5 to individuals under this paragraph that differ
 6 in type, amount, duration, or scope from the
 7 home and community-based services offered for
 8 individuals who satisfy the needs-based criteria
 9 established under paragraph (1)(A), so long as
 10 such services are within the scope of services
 11 described in paragraph (4)(B) of subsection (c)
 12 for which the Secretary has the authority to ap-
 13 prove a waiver and do not include room or
 14 board.

15 “(7) STATE OPTION TO OFFER HOME AND COM-
 16 MUNITY-BASED SERVICES TO SPECIFIC, TARGETED
 17 POPULATIONS.—

18 “(A) IN GENERAL.—A State may elect in
 19 a State plan amendment under this subsection
 20 to target the provision of home and community-
 21 based services under this subsection to specific
 22 populations and to differ the type, amount, du-
 23 ration, or scope of such services to such specific
 24 populations.

25 “(B) 5-YEAR TERM.—

1 “(i) IN GENERAL.—An election by a
2 State under this paragraph shall be for a
3 period of 5 years.

4 “(ii) PHASE-IN OF SERVICES AND ELI-
5 GIBILITY PERMITTED DURING INITIAL 5-
6 YEAR PERIOD.—A State making an elec-
7 tion under this paragraph may, during the
8 first 5-year period for which the election is
9 made, phase-in the enrollment of eligible
10 individuals, or the provision of services to
11 such individuals, or both, so long as all eli-
12 gible individuals in the State for such serv-
13 ices are enrolled, and all such services are
14 provided, before the end of the initial 5-
15 year period.

16 “(C) RENEWAL.—An election by a State
17 under this paragraph may be renewed for addi-
18 tional 5-year terms if the Secretary determines,
19 prior to beginning of each such renewal period,
20 that the State has—

21 “(i) adhered to the requirements of
22 this subsection and paragraph in providing
23 services under such an election; and

1 “(ii) met the State’s objectives with
 2 respect to quality improvement and bene-
 3 ficiary outcomes.”.

4 (c) REMOVAL OF LIMITATION ON SCOPE OF SERV-
 5 ICES.—Paragraph (1) of section 1915(i) of the Social Se-
 6 curity Act (42 U.S.C. 1396n(i)), as amended by sub-
 7 section (a), is amended by striking “or such other services
 8 requested by the State as the Secretary may approve”.

9 (d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE
 10 FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING
 11 HOME AND COMMUNITY-BASED SERVICES UNDER A
 12 STATE PLAN AMENDMENT.—

13 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
 14 of the Social Security Act (42 U.S.C.
 15 1396a(a)(10)(A)(ii)) is amended—

16 (A) in subclause (XVIII), by striking “or”
 17 at the end;

18 (B) in subclause (XIX), by adding “or” at
 19 the end; and

20 (C) by inserting after subclause (XIX), the
 21 following new subclause:

22 “(XX) who are eligible for home
 23 and community-based services under
 24 needs-based criteria established under
 25 paragraph (1)(A) of section 1915(i),

1 or who are eligible for home and com-
 2 munity-based services under para-
 3 graph (6) of such section, and who
 4 will receive home and community-
 5 based services pursuant to a State
 6 plan amendment under such sub-
 7 section;”.

8 (2) CONFORMING AMENDMENTS.—

9 (A) Section 1903(f)(4) of the Social Secu-
 10 rity Act (42 U.S.C. 1396b(f)(4)) is amended in
 11 the matter preceding subparagraph (A), by in-
 12 serting “1902(a)(10)(A)(ii)(XX),” after
 13 “1902(a)(10)(A)(ii)(XIX),”.

14 (B) Section 1905(a) of the Social Security
 15 Act (42 U.S.C. 1396d(a)) is amended in the
 16 matter preceding paragraph (1)—

17 (i) in clause (xii), by striking “or” at
 18 the end;

19 (ii) in clause (xiii), by adding “or” at
 20 the end; and

21 (iii) by inserting after clause (xiii) the
 22 following new clause:

23 “(xiv) individuals who are eligible for home and
 24 community-based services under needs-based criteria
 25 established under paragraph (1)(A) of section

1 1915(i), or who are eligible for home and commu-
 2 nity-based services under paragraph (6) of such sec-
 3 tion, and who will receive home and community-
 4 based services pursuant to a State plan amendment
 5 under such subsection,”.

6 (e) ELIMINATION OF OPTION TO LIMIT NUMBER OF
 7 ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR
 8 GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA
 9 IS MODIFIED.—Paragraph (1) of section 1915(i) of such
 10 Act (42 U.S.C. 1396n(i)) is amended—

11 (1) by striking subparagraph (C) and inserting
 12 the following:

13 “(C) PROJECTION OF NUMBER OF INDIV-
 14 VIDUALS TO BE PROVIDED HOME AND COMMU-
 15 NITY-BASED SERVICES.—The State submits to
 16 the Secretary, in such form and manner, and
 17 upon such frequency as the Secretary shall
 18 specify, the projected number of individuals to
 19 be provided home and community-based serv-
 20 ices.”; and

21 (2) in subclause (II) of subparagraph (D)(ii),
 22 by striking “to be eligible for such services for a pe-
 23 riod of at least 12 months beginning on the date the
 24 individual first received medical assistance for such
 25 services” and inserting “to continue to be eligible for

1 such services after the effective date of the modifica-
 2 tion and until such time as the individual no longer
 3 meets the standard for receipt of such services under
 4 such pre-modified criteria”.

5 (f) ELIMINATION OF OPTION TO WAIVE
 6 STATEWIDENESS; ADDITION OF OPTION TO WAIVE COM-
 7 PARABILITY.—Paragraph (3) of section 1915(i) of such
 8 Act (42 U.S.C. 1396n(3)) is amended by striking
 9 “1902(a)(1) (relating to statewideness)” and inserting
 10 “1902(a)(10)(B) (relating to comparability)”.

11 (g) EFFECTIVE DATE.—The amendments made by
 12 this section take effect on the first day of the first fiscal
 13 year quarter that begins after the date of enactment of
 14 this Act.

15 **SEC. 4202. MANDATORY APPLICATION OF SPOUSAL IMPOV-**
 16 **ERISHMENT PROTECTIONS TO RECIPIENTS**
 17 **OF HOME AND COMMUNITY-BASED SERVICES.**

18 (a) IN GENERAL.—Section 1924(h)(1)(A) of the So-
 19 cial Security Act (42 U.S.C. 1396r–5(h)(1)(A)) is amend-
 20 ed by striking “(at the option of the State) is described
 21 in section 1902(a)(10)(A)(ii)(VI)” and inserting “is eligi-
 22 ble for medical assistance for home and community-based
 23 services under subsection (c), (d), (e), or (i) of section
 24 1915”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 subsection (a) takes effect on October 1, 2009.

3 **SEC. 4203. STATE AUTHORITY TO ELECT TO EXCLUDE UP**
 4 **TO 6 MONTHS OF AVERAGE COST OF NURS-**
 5 **ING FACILITY SERVICES FROM ASSETS OR**
 6 **RESOURCES FOR PURPOSES OF ELIGIBILITY**
 7 **FOR HOME AND COMMUNITY-BASED SERV-**
 8 **ICES.**

9 (a) IN GENERAL.—Section 1917 of the Social Secu-
 10 rity Act (42 U.S.C. 1396p) is amended by adding at the
 11 end the following new subsection:

12 “(i) STATE AUTHORITY TO EXCLUDE UP TO 6
 13 MONTHS OF AVERAGE COST OF NURSING FACILITY
 14 SERVICES FROM HOME AND COMMUNITY-BASED SERV-
 15 ICES ELIGIBILITY DETERMINATIONS.—Nothing in this
 16 section or any other provision of this title, shall be con-
 17 strued as prohibiting a State from excluding from any de-
 18 termination of an individual’s assets or resources for pur-
 19 poses of determining the eligibility of the individual for
 20 medical assistance for home and community-based services
 21 under subsection (c), (d), (e), or (i) of section 1915 (if
 22 a State imposes an limitation on assets or resources for
 23 purposes of eligibility for such services), an amount equal
 24 to the product of the amount applicable under subsection
 25 (c)(1)(E)(ii)(II) (at the time such determination is made)

1 and such number, not to exceed 6, as the State may
2 elect.”.

3 (b) RULE OF CONSTRUCTION.—Nothing in the
4 amendment made by subsection (a) shall be construed as
5 affecting a State’s option to apply less restrictive meth-
6 odologies under section 1902(r)(2) for purposes of deter-
7 mining income and resource eligibility for individuals spec-
8 ified in that section.

9 **Subtitle C—Coordination of Home** 10 **and Community-Based Waivers**

11 **SEC. 4301. STREAMLINED PROCESS FOR COMBINED WAIV-** 12 **ERS UNDER SUBSECTIONS (B) AND (C) OF** 13 **SECTION 1915.**

14 Not later than 90 days after the date of enactment
15 of this Act, the Secretary of Health and Human Services
16 shall create a template to streamline the process of ap-
17 proving, monitoring, evaluating, and renewing State pro-
18 posals to conduct a program that combines the waiver au-
19 thority provided under subsections (b) and (c) of section
20 1915 of the Social Security Act (42 U.S.C. 1396n) into
21 a single program under which the State provides home and
22 community-based services to individuals based on individ-
23 ualized assessments and care plans (in this section re-
24 ferred to as the “combined waivers program”). The tem-

1 plate required under this section shall provide for the fol-
2 lowing:

3 (1) A standard 5-year term for conducting a
4 combined waivers program.

5 (2) Harmonization of any requirements under
6 subsections (b) and (c) of such section that overlap.

7 (3) An option for States to elect, during the
8 first 5-year term for which the combined waivers
9 program is approved to phase-in the enrollment of
10 eligible individuals, or the provision of services to
11 such individuals, or both, so long as all eligible indi-
12 viduals in the State for such services are enrolled,
13 and all such services are provided, before the end of
14 the initial 5-year period.

15 (4) Examination by the Secretary, prior to each
16 renewal of a combined waivers program, of how well
17 the State has—

18 (A) adhered to the combined waivers pro-
19 gram requirements; and

20 (B) performed in meeting the State's ob-
21 jectives for the combined waivers program, in-
22 cluding with respect to quality improvement
23 and beneficiary outcomes.

1 **TITLE V—HOME AND COMMU-**
 2 **NITY-BASED SERVICES PROVI-**
 3 **SIONS**

4 **SEC. 5001. SHORT TITLE.**

5 This Act may be cited as the “Project 2020: Building
 6 on the Promise of Home and Community-Based Services
 7 Act of 2009”.

8 **SEC. 5002. LONG-TERM SERVICES AND SUPPORTS.**

9 The Social Security Act (42 U.S.C. 301 et seq.) is
 10 amended by adding at the end the following:

11 **“TITLE XXII—LONG-TERM**
 12 **SERVICES AND SUPPORTS**

13 **“SEC. 2201. DEFINITIONS.**

14 “Except as otherwise provided, the terms used in this
 15 title have the meanings given the terms in section 102 of
 16 the Older Americans Act of 1965 (42 U.S.C. 3002).

17 **“Subtitle A—Single-Entry Point**
 18 **System Program**

19 **“SEC. 2211. STATE SINGLE-ENTRY POINT SYSTEMS.**

20 “(a) DEFINITIONS.—In this title:

21 “(1) LONG-TERM SERVICES AND SUPPORTS.—

22 The term ‘long-term services and supports’ means
 23 any service (including a disease prevention and
 24 health promotion service, an in-home service, or a

1 case management service), care, or item (including
 2 an assistive device) that is—

3 “(A) intended to assist individuals in cop-
 4 ing with, and, to the extent practicable, com-
 5 pensating for, functional impairment in car-
 6 rying out activities of daily living;

7 “(B) furnished at home, in a community
 8 care setting, including a small community care
 9 setting (as defined in section 1929(g)(1)) and a
 10 large community care setting (as defined in sec-
 11 tion 1929(h)(1)), or in a long-term care facility;
 12 and

13 “(C) not furnished to diagnose, treat, or
 14 cure a medical disease or condition.

15 “(2) SINGLE-ENTRY POINT SYSTEM.—The term
 16 ‘single-entry point system’ means any coordinated
 17 system for providing—

18 “(A) comprehensive information to con-
 19 sumers and caregivers on the full range of
 20 available public and private long-term services
 21 and supports, options, service providers, and re-
 22 sources, including information on the avail-
 23 ability of integrated long-term care, including
 24 consumer directed care options;

1 “(B) personal counseling to assist individ-
2 uals in assessing their existing or anticipated
3 long-term care needs, and developing and imple-
4 menting a plan for long-term care designed to
5 meet their specific needs and circumstances;
6 and

7 “(C) consumers and caregivers access to
8 the range of publicly supported and privately
9 supported long-term services and supports that
10 are available.

11 “(b) PROGRAM.—The Secretary shall establish and
12 carry out a single-entry point system program. In carrying
13 out the program, the Secretary shall make grants to
14 States, from allotments described in subsection (c), to pay
15 for the Federal share of the cost of establishing State sin-
16 gle-entry point systems.

17 “(c) ALLOTMENTS.—

18 “(1) ALLOTMENTS TO INDIAN TRIBES AND
19 TERRITORIES.—

20 “(A) RESERVATION.—The Secretary shall
21 reserve from the funds made available under
22 subsection (g)—

23 “(i) for fiscal year 2010, \$1,962,456;
24 and

1 “(ii) for each subsequent fiscal year,
2 \$1,962,456, increased by the percentage
3 increase in the Consumer Price Index for
4 All Urban Consumers, between October of
5 the fiscal year preceding the subsequent
6 fiscal year and October 2007.

7 “(B) ALLOTMENTS.—The Secretary shall
8 use the funds reserved under subparagraph (A)
9 to make allotments to—

10 “(i) Indian tribes; and

11 “(ii) Guam, American Samoa, the
12 Commonwealth of the Northern Mariana
13 Islands, the Commonwealth of Puerto
14 Rico, and the United States Virgin Islands.

15 “(2) ALLOTMENTS TO STATES.—

16 “(A) IN GENERAL.—

17 “(i) AMOUNT.—The Secretary shall
18 allot to each eligible State for a fiscal year
19 the sum of the fixed amount determined
20 under subparagraph (B), and the alloca-
21 tion determined under subparagraph (C),
22 for the State.

23 “(ii) SUBGRANTS TO AREA AGENCIES
24 ON AGING.—

1 “(I) IN GENERAL.—Each State
2 agency receiving an allotment under
3 clause (i) shall use such allotment to
4 make subgrants to area agencies on
5 aging that can demonstrate perform-
6 ance capacity to carry out activities
7 described in this section whether such
8 area agency on aging carries out the
9 activities directly or through contract
10 with an aging network or disability
11 entity.

12 “(II) SUBGRANTS TO OTHER EN-
13 TITIES.—A State agency may make
14 subgrants described in subclause (I)
15 to other qualified aging network or
16 disability entities only if the area
17 agency on aging chooses not to apply
18 for a subgrant or is not able to dem-
19 onstrate performance capacity to
20 carry out the activities described in
21 this section.

22 “(III) SUBGRANTEE RECIPIENT
23 SUBGRANTS.—An administrator of a
24 single-entry point system established
25 by a State receiving an allotment

1 under clause (i) shall make any nec-
 2 essary subgrants to key partners in-
 3 volved in developing, planning, or im-
 4 plementing the single-entry point sys-
 5 tem. Such partners may include cen-
 6 ters for independent living (as defined
 7 in section 702 of the Rehabilitation
 8 Act of 1973 (29 U.S.C. 796a)).

9 “(B) FIXED AMOUNTS FOR STATES.—

10 “(i) RESERVATION.—The Secretary
 11 shall reserve from the funds made available
 12 under subsection (g)—

13 “(I) for fiscal year 2010,
 14 \$15,759,000; and

15 “(II) for each subsequent fiscal
 16 year, \$15,759,000, increased by the
 17 percentage increase in the Consumer
 18 Price Index for All Urban Consumers,
 19 between October of the fiscal year
 20 preceding the subsequent fiscal year
 21 and October 2007.

22 “(ii) FIXED AMOUNTS.—The Sec-
 23 retary shall use the funds reserved under
 24 clause (i) to provide equal fixed amounts to
 25 the States.

“(C) ALLOCATION FOR STATES.—The Secretary shall allocate to each eligible State for a fiscal year an amount that bears the same relationship to the funds made available under subsection (g) (and not reserved under paragraph (1) or subparagraph (B)) for that fiscal year as the number of persons who are either older individuals or individuals with disabilities in that State bears to the number of such persons or individuals in all the States.

“(D) DETERMINATION OF NUMBER OF PERSONS.—

“(i) OLDER INDIVIDUALS.—The number of older individuals in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the Bureau of the Census, and other reliable demographic data satisfactory to the Secretary.

“(ii) INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the American Community Survey,

1 and other reliable demographic data satis-
2 factory to the Secretary, on individuals
3 who have a sensory disability, physical dis-
4 ability, mental disability, self-care dis-
5 ability, go-outside-home disability, or em-
6 ployment disability.

7 “(3) ELIGIBILITY.—In addition to the States
8 determined by the Secretary to be eligible for a
9 grant under this section, a State that receives a
10 Federal grant for an aging and disability resource
11 center is eligible for a grant under this section.

12 “(4) DEFINITION.—In this subsection, the term
13 ‘State’ shall not include any jurisdiction described in
14 paragraph (1)(B)(ii).

15 “(d) APPLICATIONS.—

16 “(1) IN GENERAL.—To be eligible to receive an
17 initial grant under this section, a State agency shall,
18 after consulting and coordinating with consumers,
19 other stakeholders, and area agencies on aging in
20 the State, if any, submit an application to the Sec-
21 retary at such time, in such manner, and containing
22 the following information:

23 “(A) Evidence of substantial involvement
24 of stakeholders and agencies in the State that

1 are administering programs that will be the
2 subject of referrals.

3 “(B) The applicant shall establish or des-
4 ignate a collaborative board to ensure meaning-
5 ful involvement of stakeholders in the develop-
6 ment, planning, implementation, and evaluation
7 of a single-entry point system consistent with
8 the following:

9 “(i) The collaborative board shall be
10 composed of—

11 “(I) individuals representing all
12 populations served by the applicant’s
13 single-entry point system, including
14 older adults and individuals from di-
15 verse backgrounds who have a dis-
16 ability or a chronic condition requiring
17 long-term support;

18 “(II) a representative from the
19 local center for independent living (as
20 defined in section 702 of the Rehabili-
21 tation Act of 1973 (29 U.S.C. 796a)),
22 and representatives from other organi-
23 zations that provide services to the in-
24 dividuals served by the system and

1 those who advocate on behalf of such
2 individuals; and

3 “(III) representatives of the gov-
4 ernment and non-governmental agen-
5 cies that are affected by the system.

6 “(ii) The applicant shall work in con-
7 junction with the collaborative board on—

8 “(I) the design and operations of
9 the single-entry point system;

10 “(II) stakeholder input; and

11 “(III) other program and policy
12 development issues related to the sin-
13 gle-entry point system.

14 “(iii) An advisory board established
15 under the Real Choice Systems Change
16 Program or for an existing single-entry
17 point system may be used to carry out the
18 activities of a collaborative board under
19 this subparagraph if such advisory board
20 meets the requirements under clause (i).

21 “(C) The applicant’s plan for providing—

22 “(i) comprehensive information on the
23 full range of available public and private
24 long-term services and supports options,
25 providers, and resources, including building

1 awareness of the single-entry point system
2 as a resource;

3 “(ii) objective, neutral, and personal
4 information, counseling, and assistance to
5 individuals and their caregivers in assess-
6 ing their existing or anticipated long-term
7 care needs, and developing and imple-
8 menting a plan for long-term care to meet
9 their needs;

10 “(iii) for eligibility screening and re-
11 ferral for services;

12 “(iv) for stakeholder input;

13 “(v) for a management information
14 system; and

15 “(vi) for an evaluation of the effective-
16 ness of the single-entry point system.

17 “(D) A specification of the period of the
18 grant request, which shall include not less than
19 3 consecutive fiscal years in the 5-fiscal-year
20 period beginning with fiscal year 2010.

21 “(E) Such other information as the Sec-
22 retary determines appropriate.

23 “(2) APPLICATION FOR CONTINUATION.—

24 “(A) IN GENERAL.—A State that receives
25 an initial grant under this section shall apply,

1 after consulting and coordinating with the area
 2 agencies on aging, for a continuation of the ini-
 3 tial grant, which includes a description of any
 4 significant changes to the information provided
 5 in the initial application and such data con-
 6 cerning performance measures related to the re-
 7 quirements in the initial application as the Sec-
 8 retary shall require.

9 “(B) EFFECT.—The requirement under
 10 subparagraph (A) shall be in effect through fis-
 11 cal year 2020.

12 “(e) USE OF FUNDS.—

13 “(1) IN GENERAL.—A State that receives a
 14 grant under this section shall use the funds made
 15 available through the grant to—

16 “(A) establish a State single-entry point
 17 system, to enable older individuals and individ-
 18 uals with disabilities and their caregivers to ob-
 19 tain resources concerning long-term services
 20 and supports options; and

21 “(B) provide information on, access to,
 22 and assistance regarding long-term services and
 23 supports.

1 “(2) SERVICES.—In particular, the State sin-
2 gle-entry point system shall be the referral source
3 to—

4 “(A) provide information about long-term
5 care planning and available long-term services
6 and supports through a variety of media (such
7 as websites, seminars, and pamphlets);

8 “(B) provide assistance with making deci-
9 sions about long-term services and supports and
10 determining the most appropriate services
11 through options counseling, future financial
12 planning, and case management;

13 “(C) provide streamlined access to and as-
14 sistance with applying for federally funded long-
15 term care benefits (including medical assistance
16 under title XIX, Medicare skilled nursing facil-
17 ity services, services under title III of the Older
18 Americans Act of 1965 (42 U.S.C. 3021 et
19 seq.), the services of Aging and Disability Re-
20 source Centers), and State-funded and privately
21 funded long-term care benefits, through efforts
22 to shorten and simplify the eligibility processes
23 for older individuals and individuals with dis-
24 abilities;

1 “(D) provide referrals to the State evi-
 2 dence-based disease prevention and health pro-
 3 motion programs under subtitle B;

4 “(E) allocate the State funds available
 5 under subtitle C and carry out the State en-
 6 hanced nursing home diversion program under
 7 subtitle C; and

8 “(F) and provide information about, other
 9 services available in the State that may assist
 10 an individual to remain in the community, in-
 11 cluding the Medicare and Medicaid programs,
 12 the State health insurance assistance program,
 13 the supplemental nutrition assistance program
 14 established under the Food and Nutrition Act
 15 of 2008 (7 U.S.C. 2011 et seq.), and the Low-
 16 Income Home Energy Assistance Program
 17 under the Low-Income Home Energy Assist-
 18 ance Act of 1981 (42 U.S.C. 8621 et seq.), and
 19 such other services, as the State shall include.

20 “(3) COLLABORATIVE ARRANGEMENTS.—

21 “(A) CENTER FOR INDEPENDENT LIV-
 22 ING.—Each entity receiving an allotment under
 23 subsection (c) shall involve in the planning and
 24 implementation of the single-entry point system
 25 the local center for independent living (as de-

1 fined in section 702 of the Rehabilitation Act of
2 1973 (29 U.S.C. 796a)), which provides infor-
3 mation, referral, assistance, or services to indi-
4 viduals with disabilities.

5 “(B) OTHER ENTITIES.—To the extent
6 practicable, the State single-entry point system
7 is encouraged to enter into collaborative ar-
8 rangements with aging and disability programs,
9 service providers, agencies, the direct care work
10 force, and other entities in order to ensure that
11 information about such services may be made
12 available to individuals accessing the State sin-
13 gle-entry point system.

14 “(f) FEDERAL SHARE.—

15 “(1) IN GENERAL.—The Federal share of the
16 cost described in subsection (b) shall be 75 percent.

17 “(2) NON-FEDERAL SHARE.—The State may
18 provide the non-Federal share of the cost in cash or
19 in-kind, fairly evaluated, including plant, equipment,
20 or services. The State may provide the non-Federal
21 share from State, local, or private sources.

22 “(g) FUNDING.—

23 “(1) IN GENERAL.—The Secretary shall use
24 amounts made available under paragraph (2) to
25 make the grants described in subsection (b).

1 “(2) FUNDING.—There are authorized to be ap-
 2 propriated to carry out this section—

3 “(A) \$30,900,000 for fiscal year 2010;

4 “(B) \$38,264,000 for fiscal year 2011;

5 “(C) \$48,410,000 for fiscal year 2012;

6 “(D) \$53,560,000 for fiscal year 2013;

7 “(E) \$63,860,000 for fiscal year 2014;

8 “(F) \$69,010,000 for fiscal year 2015;

9 “(G) \$74,160,000 for fiscal year 2016;

10 “(H) \$79,310,000 for fiscal year 2017;

11 “(I) \$84,460,000 for fiscal year 2018;

12 “(J) \$89,610,000 for fiscal year 2019; and

13 “(K) \$95,790,000 for fiscal year 2020.

14 “(3) AVAILABILITY.—Funds appropriated
 15 under paragraph (2) shall remain available until ex-
 16 pended.

17 **“Subtitle B—Healthy Living** 18 **Program**

19 **“SEC. 2221. EVIDENCE-BASED DISEASE PREVENTION AND** 20 **HEALTH PROMOTION PROGRAMS.**

21 “(a) PROGRAM.—The Secretary shall establish and
 22 carry out a healthy living program. In carrying out the
 23 program, the Secretary shall make grants to State agen-
 24 cies, from allotments described in subsection (b), to pay

1 for the Federal share of the cost of carrying out evidence-
 2 based disease prevention and health promotion programs.

3 “(b) ALLOTMENTS.—

4 “(1) ALLOTMENTS TO INDIAN TRIBES AND
 5 TERRITORIES.—

6 “(A) RESERVATION.—The Secretary shall
 7 reserve from the funds made available under
 8 subsection (g)—

9 “(i) for fiscal year 2010, \$1,500,952;
 10 and

11 “(ii) for each subsequent fiscal year,
 12 \$1,500,952, increased by the percentage
 13 increase in the Consumer Price Index for
 14 All Urban Consumers, between October of
 15 the fiscal year preceding the subsequent
 16 fiscal year and October 2007.

17 “(B) ALLOTMENTS.—The Secretary shall
 18 use the reserved funds under subparagraph (A)
 19 to make allotments to—

20 “(i) Indian tribes; and

21 “(ii) Guam, American Samoa, the
 22 Commonwealth of the Northern Mariana
 23 Islands, the Commonwealth of Puerto
 24 Rico, and the United States Virgin Islands.

25 “(2) IN GENERAL.—

1 “(A) AMOUNTS.—

2 “(i) IN GENERAL.—Except as pro-
3 vided in paragraph (3), the Secretary shall
4 allot to each eligible State for a fiscal year
5 an amount that bears the same relation-
6 ship to the funds made available under this
7 section and not reserved under paragraph
8 (1) for that fiscal year as the number of
9 older individuals in the State bears to the
10 number of older individuals in all the
11 States.

12 “(ii) OLDER INDIVIDUALS.—The
13 number of older individuals in any State
14 and in all States shall be determined by
15 the Secretary on the basis of the most re-
16 cent data available from the Bureau of the
17 Census, and other reliable demographic
18 data satisfactory to the Secretary.

19 “(B) SUBGRANTS.—

20 “(i) IN GENERAL.—Each State agency
21 that receives an amount under subpara-
22 graph (A) shall award subgrants to area
23 agencies on aging that can demonstrate
24 performance capacity to carry out activities
25 under this section whether such area agen-

1 cy on aging carries out the activities di-
2 rectly or through contract with an aging
3 network entity.

4 “(ii) SUBGRANTS TO OTHER ENTI-
5 TIES.—A State agency may make sub-
6 grants described in clause (i) to other
7 qualified aging network entities only if the
8 area agency on aging chooses not to apply
9 for a subgrant or is not able to dem-
10 onstrate performance capacity to carry out
11 the activities described in this section.

12 “(3) MINIMUM ALLOTMENT.—No State shall
13 receive an allotment under this section for a fiscal
14 year that is less than 0.5 percent of the funds made
15 available to carry out this section for that fiscal year
16 and not reserved under paragraph (1).

17 “(4) ELIGIBILITY.—In addition to the States
18 determined by the Secretary to be eligible for a
19 grant under this section, a State that receives a
20 Federal grant for evidence-based disease prevention
21 is eligible for a grant under this section.

22 “(c) APPLICATIONS.—To be eligible to receive a grant
23 under this section, a State agency shall, after consulting
24 and coordinating with consumers, other stakeholders, and
25 area agencies on aging in the State, if any, submit an ap-

1 plication to the Secretary at such time, in such manner,
 2 and containing the following information:

3 “(1) A description of the evidence-based disease
 4 prevention and health promotion program.

5 “(2) Sufficient information to demonstrate that
 6 the infrastructure exists to support the program.

7 “(3) A specification of the period of the grant
 8 request, which shall include not less than 3 consecu-
 9 tive fiscal years in the 5-fiscal-year period beginning
 10 with fiscal year 2010.

11 “(4) Such other information as the Secretary
 12 determines appropriate.

13 “(d) APPLICATION FOR CONTINUATION.—

14 “(1) IN GENERAL.—A State that receives an
 15 initial grant under this section shall apply, after con-
 16 sulting and coordinating with the area agencies on
 17 aging, for a continuation of the initial grant, which
 18 application shall include—

19 “(A) a description of any significant
 20 changes to the information provided in the ini-
 21 tial application; and

22 “(B) such data concerning performance
 23 measures related to the requirements in the ini-
 24 tial application as the Secretary shall require.

1 “(2) EFFECT.—The requirement under para-
2 graph (1) shall be in effect through fiscal year 2020.

3 “(e) USE OF FUNDS.—A State that receives a grant
4 under this section shall use the funds made available
5 through the grant to carry out—

6 “(1) an evidence-based chronic disease self-
7 management program;

8 “(2) an evidence-based falls prevention pro-
9 gram; or

10 “(3) another evidence-based disease prevention
11 and health promotion program.

12 “(f) FEDERAL SHARE.—

13 “(1) IN GENERAL.—The Federal share of the
14 cost described in subsection (a) shall be 85 percent.

15 “(2) NON-FEDERAL SHARE.—The State may
16 provide the non-Federal share of the cost in cash or
17 in-kind, fairly evaluated, including plant, equipment,
18 or services. The State may provide the non-Federal
19 share from State, local, or private sources.

20 “(g) FUNDING.—

21 “(1) IN GENERAL.—The Secretary shall use
22 amounts made available under paragraph (2) to
23 make the grants described in subsection (a).

24 “(2) FUNDING.—There are authorized to be ap-
25 propriated to carry out this section—

1 “(A) \$36,050,000 for fiscal year 2010;
 2 “(B) \$41,200,000 for fiscal year 2011;
 3 “(C) \$56,650,000 for fiscal year 2012;
 4 “(D) \$77,250,000 for fiscal year 2013;
 5 “(E) \$92,700,000 for fiscal year 2014;
 6 “(F) \$103,000,000 for fiscal year 2015;
 7 “(G) \$118,450,000 for fiscal year 2016;
 8 “(H) \$133,900,000 for fiscal year 2017;
 9 “(I) \$149,350,000 for fiscal year 2018;
 10 “(J) \$157,590,000 for fiscal year 2019;

11 and

12 “(K) \$173,040,000 for fiscal year 2020.

13 “(3) AVAILABILITY.—Funds appropriated
 14 under paragraph (2) shall remain available until ex-
 15 pended.

16 **“Subtitle C—Diversion Programs**

17 **“SEC. 2231. ENHANCED NURSING HOME DIVERSION PRO-** 18 **GRAMS.**

19 “(a) DEFINITION.—In this section:

20 “(1) LOW-INCOME SENIOR.—The term ‘low-in-
 21 come senior’ means an individual who—

22 “(A) is age 75 or older; and

23 “(B) is from a household with a household
 24 income that is not less than 150 percent, and
 25 not more than 300 percent, of the poverty line.

1 “(2) NURSING HOME.—The term ‘nursing
2 home’ means—

3 “(A) a skilled nursing facility, as defined
4 in section 1819(a); or

5 “(B) a nursing facility, as defined in sec-
6 tion 1919(a).

7 “(b) PROGRAM.—

8 “(1) IN GENERAL.—The Secretary shall estab-
9 lish and carry out a diversion program. In carrying
10 out the program, the Secretary shall make grants to
11 States, from allotments described in subsection (c),
12 to pay for the Federal share of the cost of carrying
13 out enhanced nursing home diversion programs.

14 “(2) COHORTS.—The Secretary shall make the
15 grants to—

16 “(A) a first year cohort consisting of one
17 third of the States, for fiscal year 2010;

18 “(B) a second year cohort consisting of the
19 cohort described in subparagraph (A) and an
20 additional one third of the States, for fiscal
21 year 2011; and

22 “(C) a third year cohort consisting of all
23 the eligible States, for fiscal year 2012 and
24 each subsequent fiscal year.

1 “(3) READINESS.—In determining whether to
 2 include an eligible State in the first year, second
 3 year, or third year and subsequent year cohort, the
 4 Secretary shall consider the readiness of the State to
 5 carry out an enhanced nursing home diversion pro-
 6 gram under this section. Readiness shall be deter-
 7 mined based on a consideration of the following fac-
 8 tors:

9 “(A) Availability of a comprehensive array
 10 of home and community-based services.

11 “(B) Sufficient home and community-
 12 based services provider capacity.

13 “(C) Availability of housing.

14 “(D) Availability of supports for consumer-
 15 directed services, including whether a fiscal
 16 intermediary is in place.

17 “(E) Ability to perform timely eligibility
 18 determinations and assessment for services.

19 “(F) Existence of a quality assessment and
 20 improvement program for home and commu-
 21 nity-based services.

22 “(G) Such other factors as the Secretary
 23 determines appropriate.

24 “(c) ALLOTMENTS.—

25 “(1) IN GENERAL.—

1 “(A) AMOUNT.—The Secretary shall allot
2 to an eligible State (within the applicable co-
3 hort) for a fiscal year an amount that bears the
4 same relationship to the funds made available
5 under subsection (i) for that fiscal year as the
6 number of low-income seniors in the State bears
7 to the number of low-income seniors within
8 States in the applicable cohort for that fiscal
9 year.

10 “(B) LOW-INCOME SENIORS.—The number
11 of low-income seniors in any State and in all
12 States shall be determined by the Secretary on
13 the basis of the most recent data available from
14 the American Community Survey, and other re-
15 liable demographic data satisfactory to the Sec-
16 retary.

17 “(2) ELIGIBILITY.—In addition to the States
18 determined by the Secretary to be eligible for a
19 grant under this section, a State that receives a
20 Federal grant for a nursing home diversion is eligi-
21 ble for a grant under this section.

22 “(d) APPLICATIONS.—To be eligible to receive a
23 grant under this section, a State agency shall, after con-
24 sulting and coordinating with consumers, other stake-
25 holders, and area agencies on aging in the State, if any,

1 submit an application to the Secretary at such time, in
 2 such manner, and containing such information as the Sec-
 3 retary may require, including a specification of the period
 4 of the grant request, which shall include not less than 3
 5 consecutive fiscal years in the 5-fiscal-year period begin-
 6 ning with the fiscal year prior to the year of application.

7 “(e) APPLICATION FOR CONTINUATION.—

8 “(1) IN GENERAL.—A State that receives an
 9 initial grant under this section shall apply, after con-
 10 sulting and coordinating with the area agencies on
 11 aging, for a continuation of the initial grant, which
 12 application shall include—

13 “(A) a description of any significant
 14 changes to the information provided in the ini-
 15 tial application; and

16 “(B) such data concerning performance
 17 measures related to the requirements in the ini-
 18 tial application as the Secretary shall require.

19 “(2) EFFECT.—The requirement under para-
 20 graph (1) shall be in effect through fiscal year 2020.

21 “(f) USE OF FUNDS.—

22 “(1) IN GENERAL.—A State that receives a
 23 grant under this section shall carry out the fol-
 24 lowing:

1 “(A) Use the funds made available through
2 the grant to carry out an enhanced nursing
3 home diversion program that enables eligible in-
4 dividuals to avoid admission into nursing homes
5 by enabling the individuals to obtain alternative
6 long-term services and supports and remain in
7 their communities.

8 “(B) Award subgrants to area agencies on
9 aging that can demonstrate performance capac-
10 ity to carry out activities under this section
11 whether such area agency on aging carries out
12 the activities directly or through contract with
13 an aging network entity. A State may make
14 subgrants to other qualified aging network enti-
15 ties only if the area agency on aging chooses
16 not to apply for a subgrant or is not able to
17 demonstrate performance capacity to carry out
18 the activities described in this section.

19 “(2) CASE MANAGEMENT.—

20 “(A) IN GENERAL.—The State, through
21 the State single-entry point system established
22 under subtitle A, shall provide for case manage-
23 ment services to the eligible individuals.

24 “(B) USE OF EXISTING SERVICES.—In
25 carrying out subparagraph (A), the State agen-

1 cy or area agency on aging may utilize existing
 2 case management services delivery networks
 3 if—

4 “(i) the networks have adequate safe-
 5 guards against potential conflicts of inter-
 6 est; and

7 “(ii) the State agency or area agency
 8 on aging includes a description of such
 9 safeguards in the grant application.

10 “(C) CARE PLAN.—The State shall provide
 11 for development of a care plan for each eligible
 12 individual served, in consultation with the eligi-
 13 ble individual and their caregiver, as appro-
 14 priate. In developing the care plan, the State
 15 shall explain the option of consumer directed
 16 care and assist an individual, who so requests,
 17 with developing a consumer-directed care plan
 18 that shall include arranging for support services
 19 and funding. Such assistance shall include pro-
 20 viding information and outreach to individuals
 21 in the hospital, in a nursing home for post-
 22 acute care, or undergoing changes in their
 23 health status or caregiver situation.

24 “(g) ELIGIBLE INDIVIDUALS.—In this section, the
 25 term ‘eligible individual’ means an individual—

1 “(1) who has been determined by the State to
 2 be at high functional risk of nursing home place-
 3 ment, as defined by the State agency in the State
 4 agency’s grant application;

5 “(2) who is not eligible for medical assistance
 6 under title XIX; and

7 “(3) who meets the income and asset eligibility
 8 requirements established by the State and included
 9 in such State’s grant application for approval by the
 10 Secretary.

11 “(h) FEDERAL SHARE.—

12 “(1) IN GENERAL.—The Federal share of the
 13 cost described in subsection (b) shall be, for a State
 14 and for a fiscal year, the sum of—

15 “(A) the Federal medical assistance per-
 16 centage applicable to the State for the year
 17 under section 1905(b); and

18 “(B) 5 percentage points.

19 “(2) NON-FEDERAL SHARE.—The State may
 20 provide the non-Federal share of the cost in cash or
 21 in-kind, fairly evaluated, including plant, equipment,
 22 or services. The State may provide the non-Federal
 23 share from State, local, or private sources.

24 “(i) FUNDING.—

1 “(1) IN GENERAL.—The Secretary shall use
2 amounts made available under paragraph (2) to
3 make the grants described in subsection (b).

4 “(2) FUNDING.—There are authorized to be ap-
5 propriated to carry out this section—

6 “(A) \$111,825,137 for fiscal year 2010;

7 “(B) \$337,525,753 for fiscal year 2011;

8 “(C) \$650,098,349 for fiscal year 2012;

9 “(D) \$865,801,631 for fiscal year 2013;

10 “(E) \$988,504,887 for fiscal year 2014;

11 “(F) \$1,124,547,250 for fiscal year 2015;

12 “(G) \$1,276,750,865 for fiscal year 2016;

13 “(H) \$1,364,488,901 for fiscal year 2017;

14 “(I) \$1,466,769,052 for fiscal year 2018;

15 “(J) \$1,712,755,702 for fiscal year 2019;

16 and

17 “(K) \$1,712,755,702 for fiscal year 2020.

18 “(3) AVAILABILITY.—Funds appropriated
19 under paragraph (2) shall remain available until ex-
20 pended.

1 **“Subtitle D—Administration, Eval-**
 2 **uation, and Technical Assist-**
 3 **ance**

4 **“SEC. 2241. ADMINISTRATION, EVALUATION, AND TECH-**
 5 **NICAL ASSISTANCE.**

6 “(a) ADMINISTRATION AND EXPENSES.—For pur-
 7 poses of carrying out this title, there are authorized to
 8 be appropriated for administration and expenses—

9 “(1) of the area agencies on aging—

10 “(A) \$16,825,895 for fiscal year 2010;

11 “(B) \$39,246,141 for fiscal year 2011;

12 “(C) \$50,766,948 for fiscal year 2012;

13 “(D) \$66,999,101 for fiscal year 2013;

14 “(E) \$76,979,152 for fiscal year 2014;

15 “(F) \$87,163,513 for fiscal year 2015;

16 “(G) \$98,780,562 for fiscal year 2016;

17 “(H) \$106,063,792 for fiscal year 2017;

18 “(I) \$114,324,642 for fiscal year 2018;

19 “(J) \$123,312,948 for fiscal year 2019;

20 and

21 “(K) \$133,215,845 for fiscal year 2020;

22 “(2) of the State agencies—

23 “(A) \$8,412,948 for fiscal year 2010;

24 “(B) \$19,623,071 for fiscal year 2011;

25 “(C) \$25,383,474 for fiscal year 2012;

1 “(D) \$33,499,551 for fiscal year 2013;
 2 “(E) \$38,489,576 for fiscal year 2014;
 3 “(F) \$43,581,756 for fiscal year 2015;
 4 “(G) \$49,390,281 for fiscal year 2016;
 5 “(H) \$53,031,896 for fiscal year 2017;
 6 “(I) \$57,162,321 for fiscal year 2018;
 7 “(J) \$61,656,474 for fiscal year 2019; and
 8 “(K) \$66,607,923 for fiscal year 2020;

9 and

10 “(3) of the Administration—

11 “(A) \$2,103,237 for fiscal year 2010;
 12 “(B) \$4,905,768 for fiscal year 2011;
 13 “(C) \$6,345,868 for fiscal year 2012;
 14 “(D) \$8,374,888 for fiscal year 2013;
 15 “(E) \$9,622,394 for fiscal year 2014;
 16 “(F) \$10,895,439 for fiscal year 2015;
 17 “(G) \$12,347,570 for fiscal year 2016;
 18 “(H) \$13,257,974 for fiscal year 2017;
 19 “(I) \$14,290,580 for fiscal year 2018;
 20 “(J) \$15,414,118 for fiscal year 2019; and
 21 “(K) \$16,651,981 for fiscal year 2020.

22 “(b) EVALUATION AND TECHNICAL ASSISTANCE.—

23 “(1) CONDITIONS TO RECEIPT OF GRANT.—In
 24 awarding grants under this title, the Secretary shall
 25 condition receipt of the grant for the second and

1 subsequent grant years on a satisfactory determina-
2 tion that the State agency is meeting benchmarks
3 specified in the grant agreement for each grant
4 awarded under this title.

5 “(2) EVALUATIONS.—The Secretary shall meas-
6 ure and evaluate, either directly or through grants
7 or contracts, the impact of the programs authorized
8 under this title. Not later than June 1 of the year
9 that is 6 years after the year of the date of enact-
10 ment of the Project 2020: Building on the Promise
11 of Home and Community-Based Services Act of
12 2009 and every 2 years thereafter, the Secretary
13 shall—

14 “(A) compile the reports of the measures
15 and evaluations of the grantees;

16 “(B) establish benchmarks to show
17 progress toward savings; and

18 “(C) present a compilation of the informa-
19 tion under this paragraph to Congress.

20 “(3) TECHNICAL ASSISTANCE GRANTS.—The
21 Secretary shall award technical assistance grants, in-
22 cluding State-specific grants whenever practicable, to
23 carry out the programs authorized under this title.

1 “(4) TRANSFER.—There are authorized to be
2 appropriated for such evaluation and technical as-
3 sistance under this subsection—

4 “(A) \$4,206,474 for fiscal year 2010;

5 “(B) \$9,811,535 for fiscal year 2011;

6 “(C) \$8,461,158 for fiscal year 2012;

7 “(D) \$11,166,517 for fiscal year 2013;

8 “(E) \$12,829,859 for fiscal year 2014;

9 “(F) \$14,527,252 for fiscal year 2015;

10 “(G) \$16,463,427 for fiscal year 2016;

11 “(H) \$17,677,299 for fiscal year 2017;

12 “(I) \$19,054,107 for fiscal year 2018;

13 “(J) \$20,552,158 for fiscal year 2019; and

14 “(K) \$22,202,641 for fiscal year 2020.

15 “(c) AVAILABILITY.—Funds appropriated under this
16 section shall remain available until expended.”.

○